Maternal and Child Health Services
Title V Block Grant

State Narrative for Oklahoma

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Assurances Non-Construction Programs, Form 424B, is signed by the Oklahoma Commissioner of Health. The Certifications regarding debarment and suspension, drug-free workplace requirements, lobbying, Program Fraud Civil Remedies Act (PFCR), and environmental tobacco smoke are also signed by the Oklahoma Commissioner of Health. The original signed documents are kept in a central folder in the Maternal and Child Health Service (MCH) at the Oklahoma State Department of Health. Copies are available upon request by contacting MCH Administration at (405)271-4480 or paulaw@health.ok.gov.
/2010/ All assurances and certifications have been signed by Oklahoma's new Commissioner of Health, Dr. Terry Cline. The original signed documents continue to be kept in MCH Administration. Copies are available by contacting MCH Administration at (405) 271-4480 or paulaw@health.ok.gov //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Oklahoma provides access for public input to the Title V Maternal and Child Health (MCH) Block Grant throughout the year via an active link to the federal Maternal and Child Health Bureau (MCHB), Title V Information System (TVIS) website. This active link titled, Public Input Sought For Maternal and Child Health Service Block Grant, is found at the bottom of the Oklahoma Maternal and Child Health Service (MCH) web page,www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/ ,on the Oklahoma State Department of Health's (OSDH) website. Information on how the public may forward input on the grant is provided on the MCH web page directly under the active link. The Children with Special Health Care Needs Program (CSHCN), Oklahoma Department of Human Services (OKDHS), has a link to the OSDH MCH web page on the CSHCN web page, http://www.okdhs.org/programsandservices/health/cshcn/ on the OKDHS website. Hard copies of the Title V MCH Block Grant are also provided on request to MCH Administration at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

Public input via e-mail, letters and telephone calls has been received intermittently throughout the year. MCH and CSHCN use this public input in evaluation, planning and development of policies, procedures and services that are reported and described in the Title V MCH Block Grant annual report and application for submission to the MCHB.

/2009/ Access to Oklahoma's Title V MCH Block Grant continues to be provided to the public via an active link to the federal MCHB TVIS website. The Oklahoma MCH web address changed this

year as the OSDH website was migrated to the state portal system, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/. Information on how the public may forward input is provided on the MCH web page directly under the active link. CSHCN continues to maintain an active link on the CSHCN web page, http://www.okdhs.org/programsandservices/health/cshcn/, to the OSDH MCH web page. Hard copies of the Title V MCH Block Grant are also provided on request to MCH Administration at (405) 271-4480 or via e-mail to Paulaw@health.ok.gov.

The use of an annual statewide press release is unchanged. The press release for this year was disseminated January 22, 2008. In addition, an article was published in the Oklahoma Hospital Association Newsletter, "Hotline", on January 23, 2008.

MCH and CSHCN use public input received in evaluation, planning and development of policies, procedures and services that are reported and described in the Title V MCH Block Grant annual report and application submitted to the MCHB. //2009//

/2010/ Access to Oklahoma's Title V MCH Block Grant Annual Report and Application remains unchanged.

The use of the statewide press release has also continued. This year the press release was disseminated on February 3, 2009 and published in several newspapers and electronic news reports across the state.

MCH and CSHCN continued to use the input received to evaluate and develop policies, services and procedures described in the Block Grant narrative.

In beginning to obtain public input as part of the Title V MCH Five Year Needs Assessment due July 2010, Oklahoma developed a brief survey using the SurveyMonkey tool. The electronic link to the survey was shared via e-mail communications and in written form such as postcards and fliers. Response to the use of an electronic survey has been positive. Routine use of an electronic survey is being considered as an additional means to gain public input each year. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Oklahoma Title V 2005-2010 Needs Assessment is available on the Maternal and Child Health Bureau (MCHB) Title V Information System (TVIS) website and may be accessed via an active link titled, "Public Input Sought For Maternal and Child Health Service Block Grant", found at the bottom of the Maternal and Child Health Service (MCH) web page, http://www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/. On the MCHB TVIS website, click on topic "State Needs Assessments (2005)" then click on "Oklahoma" in the list of states.

/2008/ Oklahoma's infant mortality rate (IMR) has consistently remained above the national rate since 1992. While some improvements have been observed, the state's IMR of 8.1 deaths per 1,000 live births for 2005 is no better than the national rate of 8.0 achieved over 10 years earlier. The Oklahoma rate has seen little change since 1992 except for a couple of anomalous years, dropping by 10% from 9.0 in 1990 to 8.1 in 2005. In comparison, the U.S. rate dropped by 25% from 9.2 in 1990 to 6.9 in 2003.

Mortality by race reveals a large, persistent disparity between white and African American rates. The African American IMR is more than twice the rate of white deaths, and little has changed for decades. The differences between white deaths and Native American/American Indian deaths are subtler within Oklahoma due to misclassification of mixed race infants. Racial variances in mortality may be due more to cultural and discrimination issues rather than racially genetic differences; more study is needed to separate these effects. Moreover, intervention methods for non-white races have not been sensitive to recognizing the need for culturally different approaches to improving health outcomes. The increasing Hispanic influence in Oklahoma has heightened this disparity. It has actually been easier to address Hispanic cultural difference most likely because the language barrier demands it. This is not a scientific observation; rather, it is observational according to the health care delivery systems with whom the Oklahoma State Department of Health (OSDH) supports and collaborates.

Hispanic infant mortality in Oklahoma is more difficult to identify due to the immigration of families from non-U.S. locations over the past decade. There is evidence of newly immigrated Hispanic mothers having a greater likelihood of delivering normal weight babies than Hispanic mothers who have been living in Oklahoma for longer periods. The assumption is that acculturation has led to the adoption of poorer dietary practices common among the U.S. population. However, the infant mortality rate for Hispanic babies is not equally low. The data are small and there is not a sufficiently long history to verify true differences. But with the reported data, the IMR for Hispanic infants has been consistently worse than that for whites; the rates have typically been 10% - 20% higher than the white rate. If there are protective factors that allow Hispanic mothers to have healthier babies, the same cannot be said after the infant is born.

From 1990 to 2005, the white IMR was reduced from 8.7 to 7.3, a 16% drop. For African Americans, the rate actually increased by 11% from 13.9 to 15.4. The traditional calculation of Native American IMR also showed an increase of 13% from 6.8 in 1990 to 7.7 in 2005. The rates for minority races in Oklahoma are highly variable due to the relatively small number of deaths each year; however, the lack of a decrease during this 16 year period still reflects problems that need to be addressed among Native Americans and African Americans in Oklahoma.

The OSDH has made the reduction of infant mortality one of its priorities. An intra-agency

workgroup has been convened to study the different aspects of the state's high infant mortality rate. Initial analyses reveal no startling differences among the primary causes of infant deaths than reported for the nation as a whole. The racial disparities also do not reveal any quick answers. Comparing Oklahoma to bordering states reveals that Kansas, Colorado, New Mexico, and even Texas have much lower rates than observed in Oklahoma. The most recent and final data from the National Center for Health Statistics (NCHS) shows that Missouri, Arkansas, and Louisiana all have higher rates, but that was for 2003 when Oklahoma reported a questionably low rate of 7.8 that bettered Missouri for that one year. This is not to imply that the rate was incorrect for that year, but rather the year itself did not represent a rate that has been typically reported for the state.

Perhaps some of the most important issues surrounding the state's poor performance in maintaining healthy infants are those social and economic differences that impact health outcomes. These issues will be the greatest challenge for the task force to measure, because they are not collected through vital registration records. Therefore, it is equally important to identify mothers and families within the state who do achieve non-fatal outcomes for their infants and determine what factors contribute to those favorable outcomes. //2008//

/2009/A minor decline in the infant mortality rate was observed for 2006, dropping from 8.1 to 8.0 deaths per 1,000 live births. However, the African American infant mortality 2002-2006 averaged annual rate is still 15.5, compared to the white rate of 6.7 for the same five-year period. A review of cases from the two Oklahoma Fetal and Infant Mortality Review projects reveals a high incidence of maternal overweight/obesity and infections among infants who have died. Further review is needed to verify these relationships and determine what interventions are best suited to reduce these prenatal conditions.

Results from the 2007 Youth Risk Behavior Survey were received and are incorporated into Performance Measures, Health Status Indicators, and other reports as appropriate.

OSDH conducted a survey of practicing obstetricians providing delivery services in the state from 2003 - 2005. Nearly 73% of responding physicians reported medical liability premiums as a very important barrier to providing obstetric care. More than one-fourth of respondents rated uninsured clients as a very important obstacle to providing obstetric care, and 46% of those reporting indicated low Medicaid reimbursement to be a very important barrier to providing care to the SoonerCare (Medicaid) clients.

For a status update addressing the Community Needs Assessment (Key Informant Survey) for CHSCN, see notes on National Performance Measure #2. //2009//

/2010/ Data from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), vital records and FIMR projects were used by the OSDH intra-agency workgroup to address reduction of IMR in Oklahoma and to expand the OSDH efforts into a statewide effort. PRAMS data and findings from a hospital nurse survey led to identification of a new state performance measure (see IV. Priorities, Performance and Program Activities, B. State Priorities). The ability to link Medicaid data, gained over the past year, to vital statistics and PRAMS data will help draw a more complete picture of needs, both met and unmet in the state. //2010//

III. State Overview

A. Overview

Oklahoma is a largely rural state with two major metropolitan areas, one located centrally in the state (Oklahoma City) and the other 104 miles to the east (Tulsa). In each of the quadrants and the panhandle of the state, smaller cities provide some of the benefits of the two large metropolitan areas on a lesser scale. Scattered throughout the remainder of the state are rural towns of varying size and population. Population in rural areas is decreasing while the two large metropolitan areas have experienced the most growth over the past five years. Farming continues to shrink and small businesses struggle to survive in a climate of corporate and urban growth. Gaming (lotteries and casinos) is becoming a major contributor to the state's economy with revenue reaching nearly 1 billion this year and expected to increase.

Overall, Oklahoma is primarily Caucasian with other non-white and/or Hispanic populations being less than 22% of the state's population. Larger populations of other non-white and/or Hispanic populations are found in eastern and southeastern Oklahoma. There are 39 federally recognized Native American/American Indian tribal governments with Native American populations integrated into local communities. Oklahoma has no reservations though federally it is considered a reservation state. In recent years, a steady growth in the Hispanic population is occurring, at first in rural farming communities with movement now into growing urban communities. Pockets of predominantly African American/Black communities are found in central and eastern Oklahoma.

The total size of the maternal and child health age-targeted population including children ages 0 through 19 and females ages 20 through 44 stood at 1,572,444 or 44.6% of the total population (3,523,600) for 2004. The population of children and adolescents under the age of 18 dropped 3.6% from 2000-2004.
/2007/ Thirty-one of the state's 77 counties experienced a decrease in population from 2000 to 2004. The continued migration to the two primary metropolitan centers has also had a negative impact upon the availability of health care providers. Population losses, rising medical liability insurance costs and low Medicaid reimbursement rates have forced physicians to move or to restrict their practices. The net result has created a number of significant geographic gaps in obstetric and pediatric medical care across the state. //2007//
/2008/ Oklahoma's population grew by 1.01% from July 1, 2005 to July 1, 2006, gaining 35,000 plus residents for an estimated state population of 3,579,200. With this growth, Oklahoma ranked 22nd in population growth and 28th among the states in population. //2008//
/2009/ Oklahoma's population grew by 1.01% from July 1, 2006 to July 1, 2007, gaining 38,000 plus residents for an estimated state population of 3,617,300. Oklahoma ranked 20th in population numeric growth and 18th in fastest overall growth rate, but remained ranked 28th among the states in population. //2009//
/2010/ The total size of the maternal and child health age-targeted population increased from 1,572,444 in 2004 to 1,606,135 in 2008, an increase of 33,691 persons within the MCH population. Children, ages 0 through 19, numbered 1,005,750 or 27.7% and females, ages 20 through 44, stood at 600,385 or 16.5% of the total population (3,642,360) for 2008. The percent change in the MCH population decreased from 44.7% in 2004 to 44.1% in 2008. //2010//

Oklahoma is a poor state even though the state's economy is currently performing well with general revenue fund collections and additional funds being received from gross production tax on oil and natural gas. The 2003 per capita personal income for the state was $26,719 (85% of the national value) with only eleven other states reporting lower per capita incomes. Unemployment stood at 4.5% in April 2005. However, even with relatively low unemployment, the state suffers from high rates of uninsured persons. Many jobs are low wage and temporary positions (e.g., call centers, live stock processing, lawn/garden services).
/2007/ Record revenues were reported for the state fiscal year ending June 30. It was the second straight year of record collections. The economy performed well mainly due to oil and gas prices

though growth was also being seen in other sectors to include durable goods manufacturing and fabricated metal manufacturing. Questions exist about the economic impact that the closing of the Oklahoma City General Motors Plant earlier this year and the buyout in June of the Kerr-McGee Corporation, with the relocation of its headquarters to the Houston area, will have on the state.

Unemployment continues to remain below the national average with a 4.1% unemployment rate. However, Oklahoma's median personal income is still well below the national average. Although the general cost of living is less than in other regions, the cost of health insurance is not. As a result, Oklahomans have higher rates of uninsured individuals than the national averages. //2007//
/2008/ General revenues exceeded official estimates for a third year. Revenue from corporate income taxes, state sales taxes and motor vehicle taxes demonstrated gains with personal income taxes (expected secondary to tax reduction measures passed in previous years) and gross production taxes on oil and gas below estimates. State government ended the fiscal year with $151.5 million surplus as well as a full "rainy day" fund. //2008//
/2009/ Nationally, Oklahoma ranked 16th in personal income growth. Oklahoma showed a 6.6% rise in personal income for 2007, slightly better than the U.S. national average at 6.2%.

Oklahoma's per capita personal income increased in 2007 to $34,153, up from the state's previous $32,391 in 2006, though Oklahoma still ranked 33rd among all 50 states. Oklahoma also had the 19th best gain nationwide, reporting a 5.4% rise in per capita income.

The most current information from the U.S. Bureau of Labor Statistics shows Oklahoma's preliminary, monthly seasonally adjusted unemployment rate for April 2008 to be 3.2 percent, well below the national average. Oklahoma's labor force population is 1,723,919, its employment numbers are, 1,668,426, with 55,493 representing the unemployment population. Historically, Oklahoma's highest unemployment rate was reported in August 1986 at 9.4 percent. Oklahoma's lowest rate to date was recorded to be in January 2001 at 2.7 percent.

In 2007 Oklahoma ranked 23rd, tied with the state of Texas, among all states with its relatively low 4.3 percent annual unemployment rate. However, nationwide Oklahoma ranks 40th for its over-the-year change in unemployment rates, reporting a modest 0.2 percent change over the rate of 4.1 for 2006.

It has been estimated, that in 2006, Oklahoma experienced approximately 470 deaths that could be attributed to a lack of health insurance among working aged adults. Between 2000 and 2006 the number of adults aged 25 through 64 that died who lacked health insurance was estimated to be approximately 3,000. //2009//

/2010/ Nationally, Oklahoma ranked 28th in personal income growth, and showed a 5.4% rise in personal income for 2008. This was the slowest growth for Oklahoma since 2003.

State agencies received a 1.4% cut in their June allottments to end the state fiscal year with the majority also receiving cuts in their approved appropriations for state fiscal year 2010. The last state budget shortfall was in fiscal year 2003. State sales tax collections are down 11% from the previous year. Unemployment at the start of the state fiscal year was 4.1% and the price of oil, a major source of gross production tax revenue to the state, was $145 a barrel. Unemployment is now 6.2% and oil is at $68 a barrel.

The 2010 state fiscal year began July 1 with $612 million less state funds available. A fiscal year budget of $7.2 billion is approved, an amount similar to previous state fiscal years but, with an important difference, $631 million of the funds are in federal stimulus monies. The state's "rainy day" fund remains untouched. //2010//

As indicated earlier, the gaming industry is growing and becoming a significant contributor to the

state's economy. In November 2004, Oklahoma voters approved state questions that are expected to create millions more in state revenues. State Question 705 created a state lottery and State Question 712 provided for the creation of the State Tribal Gaming Act. Oklahoma's lottery is slated to begin October 1, 2005 with scratch-off lottery tickets. Electronic lottery games are to begin April 2006 and Powerball games tied to lotteries in other states are to begin October 2006. Proceeds from the lottery are earmarked to support state education. The State Tribal Gaming Act authorizes a limited number of electronic games at three of the four horserace tracks in the state (Remington Park, Blue Ribbon Downs and Will Rogers Park) and provides a model compact which Indian tribes in the state may enter into to conduct such gaming on Indian lands. Related to approval of these new games under the State Tribal Gaming Act, tribal casinos are expected to continue to expand in Oklahoma. Oklahoma Indian tribes currently operate more than 80 casinos throughout the state.
/2007/ Oklahoma Instant Games went on sale October 2005. Pick3/Daily Game was introduced in November 2005. Powerball sales began in January 2006. Net proceeds of all lottery games are to support improvements and enhancements for educational purposes and programs. Net proceeds are to supplement rather than replace existing funding for education. Lottery proceeds are divided: 52% - prizes; 30% - education; 12% - operations and vendor fees; and, 6% - retailers. At least quarterly, the Oklahoma Lottery Commission transfers 30% of all net proceeds to the Oklahoma Education Lottery Trust Fund. The Office of the State Treasury administers this Trust Fund. These funds are to be distributed: 45% - kindergarten through 12th Grade Public Education, including but not limited to compensation and benefits for public school teachers and support employees, and early childhood development programs; 45% - tuition grants, loans and scholarships to citizens of the state to enable such citizens to attend colleges and universities located within the state, construction of educational, capital outlay programs and technology for all levels of education, endowed chairs for professors at institutions and programs and personnel of the Oklahoma School for the Deaf and the Oklahoma School for the Blind; 5% - Teachers' Retirement System Dedicated Revenue Revolving Fund; and, 5% - School Consolidation and Assistance Fund. Current net proceeds for education are projected to be at least $110 million a year.

Oklahoma's casino growth is reported to be second in the nation. Tribal gaming revenues topped $1.4 billion dollars in 2005 with 90 gaming centers divided among 28 tribes. Revenue grew by 39% from 2004. It is projected that similar growth will be seen in 2006 with several new casinos scheduled to open. This year is also the first full year of operation for the nation's first two tribal-owned racetrack casinos, Blue Ribbon Downs in Sallisaw and Will Rogers Downs in Claremore. //2007//
/2008/ Education received $86.3 million from lottery proceeds, short of the projected $110 million a year. Questions have been raised as to whether Oklahoma's casino industry is impacting the lottery's success.

Oklahoma experienced its fourth straight year for casino growth in 2006 accounting for the three largest Indian casinos and seven of the 15 total new casinos that opened nationally in 2006. Total Indian casinos in Oklahoma number 94. The state government's share of revenue received from the tribes more than doubled in 2006 ($30.2 million) from 2005 ($11 million). It is anticipated that the casino industry will continue to see growth with the addition of new electronic games and poker and blackjack tables in addition to the ability to draw customers from two bordering non-gambling states, Texas and Arkansas. //2008//
/2009/ 2006 revenues from Oklahoma's lottery games (the latest figures available) totaled $204,843,618. Oklahoma Education Lottery Trust Fund received $68,948,959 from lottery revenues. //2009//
/2010/ July 1, 2008 the required contribution to education from Oklahoma lottery proceeds increased from 30% to 35%. The lottery is projected to raise $191.3 million for the 2009 state fiscal year and meet its goal of earning $69.2 million for education. The second time that the goal for education has been met with the first being in 2006. The goal for 2010 has been set at $66.7 million, a $2.5 million drop from the 2009 contribution and $43.3 million less than the projected $110 million annually that was made when the lottery started in

2005.

Tribal casinos continue to grow in number with 110 currently in operation in Oklahoma. Revenue topped $2.5 billion in 2008 and is at $3 billion currently in 2009. //2010//

Oklahoma's political climate is shifting. Marked changes, attributed largely to constitutional term limits, occurred in the Oklahoma Legislature with elections in November 2004. Thirty-nine new legislators were elected to the House and fifteen new members to the Senate. For the second time in state history, Republicans gained control of the House (57 to 44) and are optimistic that they will gain control of the Senate (currently Republicans hold 22 of the 48 seats) in November 2006 when several Democratic Senators cannot seek re-election due to term limits. Democrats are a minority in the House for the first time since 1921-22 when Republicans dominated the House for one term. The House elected a Republican speaker 84 years to the day that the only other Republican was elected to the post. The House also elected the state's first female speaker pro tempore, also a Republican. These Republican House leaders work with a Democratic controlled Senate and a Democratic Governor.
/2007/ In 1990, Oklahoma became the first state in the nation to enact a legislative term-limit law. It allowed incumbent legislators to continue serving until 12 years had passed from the law's effective date in 1992. The first wave of term limits occurred in 2004. As a result of term limits after this session, more Democrats than Republicans will term limit in both the House and Senate. Republicans are looking to gain control of both the House and Senate after elections in November 2006. The elections in November will also determine the Governor of Oklahoma for the next four years with Brad Henry, the current Governor and a Democrat, to run for re-election.

New this year is the ability of the general public to more readily access information on Oklahoma's lawmaking process via a new, free website, http://www.okinsider.com/, a partnership between Oklahoma Publishing Today and NewsOK.com. Features of the site include: explanation of the legislative process in simple terms; real-time updates and live audio feeds during legislative sessions; a complete list and summary of all bills before the state Legislature; full-text versions of all bills; and, children's content. //2007//
/2008/ The November 2006 elections saw Brad Henry, the current Governor and a Democrat, re-elected as Governor of Oklahoma. The Senate, Democratic since statehood, was split with 24 Democrats and 24 Republicans. This set the stage for both parties to have an equal share of power in the Senate for the first time in the state's history. Each party had its own co-floor leader. The co-floor leaders shared the responsibility for scheduling the daily legislative calendar and rotated management of floor activities on a daily basis. Presiding duties were also shared, when one party's co-floor leader was managing floor activities, the other party presided in the chair. All Senate committees had equal numbers of Democrats and Republicans and co-chairs from each party shared the responsibility of running the committees. The House remained in Republican control with 57 of the 101 members. //2008//
/2010/ The November 2008 elections saw for the first time in state history, a sweep of both legislative bodies for the Republican party. //2010//

During this year's legislative session, several key bills were passed and signed by the Governor targeting positive outcomes for Oklahoma's maternal and child health population. These include legislation to promote good health and nutrition in the school setting, Senate Bill (SB) 265 requires healthy choices in school vending machines and SB 312 requires physical education in grades K-5 with physical education to be offered as an elective in middle and high school. With a focus on reducing child and youth automobile related morbidity and mortality, SB 799 increases the fine for violation of the Child Passenger Restraint Law from $25 to $50 plus all court costs and House Bill (HB) 1653 provides for graduated driver licenses for drivers younger than 18. It is expected with the graduated driver licenses that accidents and fatalities among drivers younger than 18 will be reduced by at least 15%. SB 435 and HB 1547 both lower state taxes. SB 435 lowers taxes by raising the standard deduction on state income taxes. HB 1547 includes a reduction in the income tax rate from 6.65% to 6.25%. In efforts to provide ongoing support for Oklahoma's youngest populations, HB 1094 ensures current levels of child care funding in the

Oklahoma Department of Human Services (OKDHS) by increasing the state's share as federal funds decrease, HB 1080 provides funding to the Oklahoma State Department of Education (OSDE) for full-day kindergarten and HB 1020 provides an additional $1 million in funding for SoonerStart, Oklahoma's early intervention program for 0 to 3 year olds. To assist with liability concerns and curb the loss of health care providers in rural areas of the state providing services through the Oklahoma State Department of Health (OSDH) system, SB 983 amends the Maternal and Infant Care Improvement Act to provide coverage under the Government Tort Claims Act for licensed health care providers contracting with the OSDH.
/2007/ MCH serves as a resource and provides education to state legislators and their staff prior to and during the legislative session each year to assist in the setting of state policy and procedure (e.g., this year: access to health care, breastfeeding, injury prevention, school health, child welfare). Analyses of bills are accomplished each year during session to identify issues that may present obstacles to improving the health of Oklahoma's maternal and child health population. These written analyses are shared with legislators and their legislative staff through the OSDH Legislative Liaison. MCH also participates in state boards, taskforces, workgroups and committees during and between sessions per request of members of the state Legislature or as appointed by the Governor. MCH is able to provide to the legislative process the latest in national health care policy and practice; information on national, regional and state health care issues and practices; and, the most recent available national, regional and state data for the maternal and child health population.

Another means afforded to MCH each year for involvement in the legislative process is participation in the Oklahoma Legislative Fall Forum. This annual event sponsored by the Oklahoma Institute for Child Advocacy, brings maternal and child advocates from the state, regional, county and community levels together to focus on MCH health issues and set a legislative agenda. MCH has worked with the Oklahoma Institute for Child Advocacy to include CSHCN in the planning of this year's Fall Forum to include developing a section focused on the needs of children with special health care needs and their families.

In 2006, for the first time in over 80 years, the Oklahoma Legislature adjourned without appropriating funds for the operations of state government. The Oklahoma Legislature closed its regular session at 5 p.m. the last Friday of May as required by state constitution without resolving state budget issues. Governor Henry called a special session to allow for a state budget to be approved before the new fiscal year started July 1 and avoid shut down of state agencies. Lawmakers were at odds over budget issues related to tax cuts, increased funding for education and a state employee pay raise. On Friday, June 23, the last day of the special session, lawmakers approved a $7.1 billion budget, the largest in state history, that includes the largest tax cut in state history and changes the state's tax structure. Lawmakers approved reducing the state income tax from 6.25% to 5.25% within four years, eliminating the inheritance tax in three years and increasing the state's standard deduction to the federal level in four years. As part of the state budget, teachers received a $3,000 pay increase, higher education received $130 million and state employees received a 5% pay increase.
Despite disagreement between the House and Senate over how to deal with budgeting of state revenue, the Oklahoma Legislature passed multiple bills before the end of the regular session to improve outcomes for the maternal and child health population. The Governor has signed all these bills.

SB 1737, the Dental Loan Repayment Act, creates a program designed to increase the number of dentists serving and caring for those dependent upon the state for dental care and to make dental care accessible to underserved metropolitan and rural areas. Educational loan repayment assistance will be provided for up to five Oklahoma licensed dentists per year, for a two to five year period per dentist. HB 2358 provides guidelines for employers to create a positive environment for mothers who wish to continue breastfeeding their babies after returning to work. This legislation builds upon positive changes made in prior years to state statute on breastfeeding. SB 990 creates the Oklahoma Genetics Counseling Licensure Act that provides a means for the OSDH Board of Health to set standards and requirements for genetic counselors.

With advances in genetics helping physicians identify and treat genetic disorders in newborns in order to ensure optimal healthy outcomes and with all newborns born in Oklahoma receiving screening for metabolic and hearing disorders in order to provide early and comprehensive follow-up services, the complexity of genetic issues has emerged as a discipline to help educate individuals, families and physicians so that better informed decisions may be made regarding health care.

Strategies to reduce risk-taking behaviors and injuries include HB 3056 and SB 1495. HB 3056 creates the Prevention of Youth Access to Alcohol Act and puts stiffer penalties in place to help curb youth access to beer. All three parties involved - the minor, the server and the owner of the store - will receive meaningful penalties, from minors losing their driver license to store owners losing their license to sell beer. SB 1495 specifically addresses boating safety. This bill prohibits children under age 16 from operating large boats or personal watercraft without first completing a course in boating safety and requiring children ages 12-16 to always have an adult present when boating or operating a personal watercraft.

Measures targeting ways for schools to be more involved in improving the health of children include SB 1459 that requires school districts to establish school wellness and fitness policies that meet specified minimum requirements. The measure directs the OSDE, in consultation with the OSDH, to make information and assistance available to schools on request. The bill requires districts to provide annual reports to the OSDE on the district's wellness policy, goals, guidelines and progress in implementing the policy and attaining the goals. HB 2655 establishes the Oklahoma Farm to School Program within the Oklahoma Department of Agriculture to connect local schools to fresh produce provided by local farmers. It is anticipated that this approach will improve the nutrition and health of Oklahoma school children, while at the same time provide new markets for Oklahoma farmers. SB 1795 requires children in grades K, 1 and 3 to receive a vision screening prior to entry to school and recommends that children who fail the screening undergo a comprehensive eye exam. The OSDH Board of Health is to develop and approve rules to facilitate implementation of this law.

Bills to improve the child welfare system in protecting the health and safety of children include: HB 2840 enacts a number of measures to bring more accountability to the child welfare and judiciary systems; HB 2126 recreates the Child Death Review Board until 7/1/2012; SB 1800 establishes the Child Abuse Response Team (CART) within the Oklahoma State Bureau of Investigation to assist in the investigation of child abuse cases; and, HB 2097 provides annual training for teachers in the recognition and reporting of child abuse and neglect. //2007// /2008/ On Friday, May 25, the 2007 regular session of the Oklahoma Legislature adjourned. The 2007 Oklahoma legislative session experienced the impact of term limits with over two-thirds of the members having less than three years experience. The four-month session (February-May) was also dominated by a power struggle between the Republican-dominated Legislature and Democratic Governor over the state budget. After vetoing in March a general appropriations measure Governor Henry said was negotiated without his input, Governor Henry and the Legislature reached agreement on a state budget May 14 that will fund state government agencies and programs in the fiscal year starting July 1. The budget, just over $7 billion, is approximately 1% less than the 2007 state fiscal year budget.

Cuts in state tax continued for a third straight year. Record level tax cuts were seen in 2005 and 2006 for Oklahomans. 2007 legislation, SB 861, was passed to speed up implementation of the tax cuts provided in 2006. It reduces the state's top income tax rate from the current 6.65% down to 5.25% by 2009, a year ahead of the previously identified 2010 date. The new law also provides a tax credit for stay-at-home parents creating equal footing with those parents who use day care. Because the current oil and gas income has increased to offset the recent tax cuts, the state has not experienced as significant an impact on lost revenues as would have occurred if oil prices had dropped or production had declined. These changes are again making the state's economy more petroleum-dependent.

Differences between the Legislature and Governor impacted tort reform. Efforts to put forth acceptable changes in the way lawsuits involving personal injury, "torts", in Oklahoma are handled were hampered by disagreement over capping non-economic damages, damages awarded for "pain and suffering" over and above an award for actual economic damages. Governor Henry vetoed the bill put forth by the Legislature, indicating a need to look at a measure that allowed the jury and the judge upon certain findings to lift the cap when appropriate and justified by the injuries. A compromise was unable to be reached before the end of the legislative session setting the stage for tort reform to be listed as a top priority for the 2008 legislative session as it has been each year since 2004.

A significant measure signed into law was HB 1804, an immigration reform bill that creates barriers for undocumented residents to receive public benefits and jobs. The "Oklahoma Taxpayer and Citizen Protection Act" passed in the House, 88-14, and the Senate, 41-6. This state law, signed by the Governor, takes effect November 1 and includes criminal penalties for knowingly and willingly harboring illegal immigrants; prohibits public benefits to individuals 14 years of age or older in the state illegally, except the provision of immunizations, treatment of communicable diseases and treatment of medical emergencies; and, requires businesses to check the background of all workers through a federal verification system or risk penalties and legal action. Health care providers statewide are expressing concerns about the consequences this law will have on Oklahoma's public health. This legislation is considered to be the most restrictive of any current state law in the United States (U.S.).

Other key bills passed impacting the MCH population include HB 1686, HB 1078, HB 1895 and SB 0639. HB 1686 requires persons under age 18 to wear a crash helmet while operating or riding as a passenger on an all--terrain vehicle (ATV) on public lands. The measure prohibits passengers on ATVs unless the vehicle was designed to carry passengers. The measure also creates penalties for non-compliance with the law. HB 1078 provides for penalties to adults providing liquor or a controlled substance to a minor when great bodily injury occurs not just when death occurs. HB 1895 establishes the Oklahoma Youth and Gang Violence Coordinating Council to coordinate Oklahoma's response to gang activity by reviewing and assessing the current suppression, intervention and prevention efforts to reduce gang activity and violence. SB 0639 allows the OSDH and city-county health departments, in order to maintain public health infrastructure and preparedness, to enter into contracts for professional services with physician assistants, registered nurses, advanced practice nurses, nurse midwives, registered dietitians, occupational therapists, physical therapists and speech language pathologists who have retired from state services without any waiting period. //2008//
/2009/ November 1, 2007, the OSDH Office of General Counsel distributed a written memorandum identify programs or services of the OSDH that were determined to be free of the lawful presence verification requirement (Section 8 of HB 1804). Programs under the administration of Maternal and Child Health Service were on this list.

On Friday, May 23, the 2008 regular session of the Oklahoma Legislature adjourned. Multiple bills were passed focused on maternal and child health. All four bills addressing childhood obesity passed; SB 1186 doubles the number of minutes of physical activity for students in grades K-5, from 60 minutes per week to 120 minutes per week; HB 1612 creates a grant program for after-school programs to incorporate obesity-reduction components; SB 519 directs the State Health Department to develop fitness testing software to pilot in several elementary schools to acquire a baseline of data; and, HB 3395 establishes a school health coordinator pilot program to assist schools to implement health and wellness programs. Additional bills targeting school health included SB 923 that requires school districts to have automated external defibrillators at each school and HB 2239 that directs schools to allow the self-administration of anaphylaxis medication to a student.

SB 551 Forget-Me-Not Vehicle Safety Act was passed which prohibits parents and guardians from leaving children six years of age or younger, or vulnerable adults, unattended in a motor vehicle if the conditions, including, but not limited to, extreme weather, present a risk to the health

or safety the child or vulnerable adult.

In efforts to enhance the health care workforce, SB 1729 creates a scholarship program to attract more faculty and students into the health care profession. Parts of 58 of Oklahoma's 77 counties are designated as medically underserved, especially related to prenatal and delivery services. Current information indicates that Oklahoma will be faced with added shortfalls in nursing and allied health professionals by 2012. //2009//
/2010/ The 2009 legislative session ended in May with what many in Oklahoma are calling a sweeping reform of the child welfare system. The work of a legislative task force created in 2006 through the Kelsey Smith Briggs Act resulted in a complete rewrite of the Children's Code (HB 2028) and Juvenile Code (HB 2029) to provide the foundation and process for state intervention into the parent-child relationship when circumstances threaten the safety of the child. HB 1734 included recommendations for changes for the OKDHS based on a performance audit. These pieces of legislation will have significant impact on the safety and well being of infants and children.

Other key pieces of legislation signed by the Governor impacting MCH populations: HB 2026 creates the Health Care for Oklahomans Act, directing the Oklahoma Health Care Authority, in collaboration with the Insurance Department, to establish the Heath Care for the Uninsured Board (HUB), a new state infrastructure designed to connect Oklahomans with health insurance; HB 1742 requires the OKDHS to conduct criminal records search for all child care employees and persons residing in a child care home; SB 135 addresses increasing the number of qualified providers to treat children with Autism Spectrum Disorder (ASD); SB 399 addresses prevention of childhood obesity by establishing the Safe Routes to Schools program to provide grants to communities for projects to help elementary and middle school children safely walk and bike to school; and, SB 1138 enacts child endangerment driving under the influence (DUI) laws.

A compromise lawsuit reform bill was also passed and signed into law. The bill puts a soft cap of $400,000 on pain and suffering (noneconomic damages). The cap could be lifted for certain circumstances. //2010//

Additional good news is the multiple opportunities presenting to increase access to health care services for the maternal and child health population. Through HB 1088, an additional $63 million in state funds has been appropriated to the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, to gain a federal match to place nearly $200 million total into the Oklahoma Medicaid system to increase provider and hospital reimbursement rates. Over the next year, it is anticipated that the OKDHS and the OHCA will finalize and implement plans to move from a six-month eligibility period to a 12-month eligibility period to facilitate continuity of care for Medicaid recipients.
/2007/ Governor Henry signed the Medicaid Reform Act, HB 2842, on June 9, 2006. This legislation is the result of a bipartisan task force that met over the past year on Medicaid reform. Though the bill was the subject of intense debates throughout the legislative session and concerns were voiced by a host of advocacy groups, the bill was passed 93-1 in the House and 46-0 in the Senate before going to the Governor. The bill allows the OHCA to seek waivers to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Oklahoma Medicaid Program. The bill includes expansion of state funding for Medicaid reimbursement for doctors and hospitals as well as outlines the framework for a new program to be phased in that will facilitate a change in the Medicaid system from a one size fits all program to one that is tailored to each client's needs. Phase one of this new program is to be implemented within a contiguous area of the state with rural and urban characteristics. The OHCA will be required to evaluate and expand the program within two years after the rural and urban program becomes operational. Upon completion of the evaluation and, if found effective, the OHCA would be required to request a waiver for statewide expansion of the program from the Centers for Medicare and Medicaid Services (CMS). Legislative intent is that components fo the program be phased in across the state within five

years from the time the measure becomes law. Other key pieces of the legislation impacting the maternal and child health population include a provision for the OHCA to apply for a waiver to extend Medicaid benefits to persons up to age 23 who are enrolled full-time in an Oklahoma college or university, implementation of a new e-prescribing system and implementation of a disease management program.

The OKDHS revised its policy on review of Medicaid eligibility for children, and adults with children, from every 6 months to every 12 months. It is anticipated that this policy change will assist in continuity of care for these populations receiving services paid by Medicaid. //2007// /2008/ The OHCA is placing a strong emphasis on communicating to Oklahomans its shift in policies and perception of its services out of the welfare system and into the health care system. Programs through the OHCA are no longer referred to as Medicaid. Programs, of varying names and benefits packages, fall under the umbrella of "SoonerCare".

July 1, 2007 policies for citizenship verification in determining eligibility for receipt of Medicaid were implemented. The OHCA has been working closely with other state agencies and providers of Medicaid funded services as state policy has been developed and training provided to lessen the impact of this new federal requirement. //2008//
/2009/ Citizenship verification continues to present a barrier with a negative impact in numbers covered by Medicaid, particularly related to children. Since implementation, total enrollment has dropped 13,000 and continues to drop monthly. //2009//
/2010/ The impact of citizenship verification continues to be monitored. From May 2008 to May 2009, the number of children enrolled in SoonerCare increased from 408,595 to 440,691. The overall percentage of SoonerCare members who were children remained around 69% as overall enrollment increased during this same period from 598,396 to 640,350. //2010//

On January 1, 2005, an expansion of the state Medicaid program began allowing breast and cervical cancer treatment for Oklahoma women less than 65 years of age. This expansion is made possible due to Governor Henry signing the Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund Act in May 2004 enabling the state to exercise the federal option under the State Medicaid Plan to provide breast and cervical cancer services for an expanded eligibility group of Oklahoma women. Women who meet eligibility criteria and have received an abnormal screen for either breast or cervical cancer are eligible for the full scope of Medicaid services through SoonerCare. Each woman will choose a primary care provider and receive needed specialty referrals through the primary care provider. In addition, she will have available care management services, transportation through SoonerRide, the SoonerCare Helpline and Nurse Advice Line. Eligible women will continue to receive services through SoonerCare until they are determined to no longer be in need of cancer treatment.
/2007/ The OHCA, OKDHS, OSDH (Chronic Disease Service and MCH), Cherokee Nation and Kaw Nation continue their partnership to provide services for low income and uninsured women between the ages of 19-65 with an abnormal screening result or in need of treatment for breast or cervical cancer. Through this partnership, 739 screening network providers have been designated across the state and 3,074 women have received services through Oklahoma Cares. //2007//
/2008/ From January 1, 2005-December 31, 2006, Oklahoma Cares served 9,334 women, who met federal poverty level (FPL) guidelines and were between the ages of 19-65, with an abnormal screening result or in need of treatment for breast or cervical cancer. There are currently 768 screening network providers. //2008//
/2009/ From January 1, 2006-December 31, 2007, Oklahoma Cares served 9,581 women between the ages of 19-65 who met FPL guidelines and had an abnormal screening result or were in need of treatment for breast or cervical cancer. There are currently 829 screening network providers. //2009//
/2010/ In 2008, physical, occupational and speech therapy services for adults became a reimbursable Medicaid benefit when provided in an outpatient setting. This rule change was to assist women with lymphedema who were previously unable to receive coverage

for lymphedema garments and physical and occupational therapies. Over 18,000 women have been served through Oklahoma Cares since 2005. There are currently 837 screening network providers. //2010//

On April 1, 2005 the Oklahoma Medicaid Family Planning Waiver was implemented. This 1115(a) research and demonstration waiver allows for family planning services to be provided to individuals who would otherwise not be eligible for Medicaid. Eligible individuals are uninsured women and men ages 19 and older with family income at or below 185% of the federal poverty level (FPL). This category includes women who gain eligibility for Title XIX (Medicaid) reproductive health services due to a pregnancy but whose eligibility ends 60 days postpartum. Medical benefits are limited to reproductive services currently covered under the state Medicaid plan.
/2007/ The OHCA, OKDHS and OSDH (MCH and the Office of Federal Funds Development) continue to work closely on activities of the Section 1115(a) Medicaid Family Planning Research and Demonstration Waiver (SoonerPlan). The OSDH participates in routine meetings with the OHCA and the OKDHS to assure ongoing communications/coordination among the partners. The OSDH also participates in regularly scheduled conference calls the OHCA has with the Centers for Medicare and Medicaid Services related to the waiver. As of the end of March, individuals approved for SoonerPlan numbered 26,226. //2007//
/2008/ Oklahoma completed its second full year of SoonerPlan on March 31, 2007. The Medicaid family planning waiver is maintaining a statewide caseload of around 20,000 serving uninsured women and men ages 19 and older with family income at or below 185% FPL. The OHCA, OKDHS and OSDH continue to meet routinely to coordinate administration of SoonerPlan. Current activities are focused on developing and implementing outreach activities to promote the program and exploring a Medicaid policy change to facilitate a smoother transition to SoonerPlan when Medicaid eligibility comes to an end for women 60 days post-partum. The Centers for Medicare and Medicaid Services completed an onsite program visit in June 2006 with several components of the program identified as best practice models. //2008//
/2009/ As of May 2008, Oklahomans currently enrolled in SoonerPlan numbered 16,617, down 3,500 individuals since implementation of citizenship verification July 1, 2007. //2009//
/2010/ April 1, 2009 began the fifth and final year of SoonerPlan. Currently, Oklahoma is documenting a savings of $8 million each quarter. A request for a new 3-year waiver will be submitted to the Centers for Medicare and Medicaid Services in the fall of 2009. The OSDH and OKDHS are working closely with the OHCA in the development of this waiver. As of the end of May 2009, 18,743 individuals were enrolled in SoonerPlan. Since the inception of the program, 67,751 individuals have received services. //2010//

Disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parent's income or resources may be eligible for services under Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248). This option allows children who are eligible for institutional services to be cared for in their homes. Only the child's income and resources are used in determining financial eligibility. The cost of care at home compared to the cost in an institutional setting is also used in determining eligibility. Children who meet eligibility requirements may be eligible for the full range of Medicaid covered services. The program implementation date is set for October 1, 2005 with income from the new tobacco tax that took effect on January 1, 2005 to provide state funds for this expansion.
/2007/ Approximately 148 families have applied for the TEFRA Program since it was implemented in November 2005 with a little over one-third of the applications approved. To be eligible for this program the child must meet the medical criteria for institutional or hospital level of care but be able to have their needs met in their own home. The most common reason children have been denied eligibility was for not meeting the medical criteria. /2007//
/2008/ Since the inception of the TEFRA Program 178 children have been approved with 149 children currently receiving services. The OHCA reports that the most common medical needs being provided under TEFRA are pharmacy, durable medical equipment and supplies, speech and hearing services and private duty nursing. //2008//
/2009/ During the past year 220 children received services through the TEFRA Program. //2009//

/2010/ Since the inception of the TEFRA Program in October 2005 to May 2009, 354 children have received services. Enrollment this May was at 276. Of these, 264 were 15 years of age and younger. //2010//

Funds generated from the new tobacco tax are also to be used to support implementation of the Premium Assistance Program. Pending CMS approval, October 1, 2005 is the target date the OHCA has identified for initiating the first phase of the Premium Assistance Program that is being implemented under a Health Insurance Flexibility and Accountability (HIFA) Waiver. This first phase of the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) allows persons who work for employers with less than 25 employees to become Medicaid eligible if household income is less than 185% FPL. Both the employee and the employer will have to pay a portion of the insurance premium. The state plans to devote an average of $50 million per year to the initiative.
/2007/ As of May, 671 individuals were enrolled in the O-EPIC. HB 2842, the Medicaid Reform Act previously described, will increase the number of Oklahomans that may be provided with health insurance coverage through Medicaid by further expanding the O-EPIC eligibility to businesses with up to 50 workers. Another initiative to be implemented under O-EPIC at the end of this year is the provision of insurance coverage through Medicaid to individuals who do not work for a qualified employer (e.g., are self-employed or unemployed but seeking work). This option will benefit some young adults who were in the CSHCN population but are now over 18, no longer eligible for traditional Medicaid and do not meet the SSI disability definition. //2007//
/2008/ Legislation passed during the 2007 session that is anticipated to improve access to health care for the MCH population were SB 424 and HB 1225, both efforts to increase health insurance coverage statewide. SB 424, also known as the "All Kids Act", expands health coverage to children 18 years of age and younger whose family income is between 185% and 300% FPL. The measure requires the OHCA to provide assistance to families in gaining health care benefits for children in the program by offering subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance provided through the state's Premium Assistance Program, O-EPIC. If privately sponsored health insurance is not available, the OHCA would allow applicants to purchase access to the state administered health care benefit under the state's Premium Assistance Program. There is the potential to provide health insurance coverage for an additional 42,000 children presently uninsured. The new program will be administered by the OHCA with plans to use a voucher system to encourage participation in the private market place. The OHCA would be authorized to offer partial coverage to children who are enrolled in a high-deductible private health insurance plan or to offer a limited package of benefits to children in families who have private or employer-sponsored health insurance coverage that does not cover benefits, including dental or vision benefits. HB 1225 expands the opportunity for working Oklahomans to obtain insurance through the Premium Assistance Program by increasing the employee cap from 50 to 250 and the minimum income eligibility to include employees whose family's income does not exceed 250% FPL. //2008//
/2009/ To date, CMS has not approved Oklahoma's request to expand health coverage to children 18 years of age and younger whose family income is between 185% and 300% FPL. In efforts to expand health care coverage, HB 2713 allows foster parents to qualify for the Insure Oklahoma Program (previously known as the O-EPIC, Oklahoma's premium assistance program) and SB 1404 authorizes the OHCA to seek waivers or amendments to expand the premium assistance program to include non-profit employers with 500 employees or less. //2009//
/2010/ Insure Oklahoma offers an Employer Sponsored Plan (ESP) that provides coverage for qualifying businesses having up to 99 employees. Family income is not to exceed 200% FPL. The Individual Plan offered under Insure Oklahoma allows individuals who cannot access benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. In March 2009, the Individual Program expanded to offer coverage to qualifying full-time Oklahoma college students age 19 through 22. As of June 2009, there were 4,752 businesses participating from across the state with 14,217 employees enrolled. The Individual Plan members were 7,381. //2010//

Given the many positive changes occurring with health care services for the maternal and child health population, Oklahoma still faces significant challenges. These include the need to improve its system of emergency/trauma care; the continuing influx of the undocumented Hispanic population and a system of care not fully prepared to deal with absorbing the additional costs of serving this population, as well as differences in culture and language; loss of physicians providing obstetric care due to high malpractice premiums; closure of obstetric units in rural hospitals due to loss of physicians and inability to meet standards of care for the provision of emergency obstetric care; and, inadequate reimbursement for health care services.

Oklahoma is working to improve its emergency medical system with the expected outcome of a fully implemented trauma system to save one in five lives currently lost. Trauma is the leading cause of death for Oklahomans ages 1 to 44 and costs Oklahomans more years of productive life than all diseases combined. Oklahoma is being divided into eight regions to pinpoint ambulance services and levels of emergency care available at each hospital within the region. Oklahoma trauma victims, classified as Priority 1, Priority 2 or Priority 3, depending on the type and severity of their injuries, will be triaged to the most appropriate hospital emergency room for treatment. The University of Oklahoma is currently the state's only Level 1 trauma center managing all types of trauma. Tulsa's St. John's and St. Francis hospitals have the state's only Level 2 trauma units. All other hospital emergency rooms are classified as either Level 3 or Level 4. On July 1, 2005, Oklahoma City and Tulsa began operating trauma triage and transfer call centers to help direct trauma victims and personnel to the most appropriate hospital emergency room. It is anticipated that this regionalization will also assist with and provide a model for addressing concerns currently faced by the state in relation to emergency obstetric and newborn care.
/2008/ In January, the new Children's Hospital opened on the University of Oklahoma Health Sciences Center (OUHSC) Campus in Oklahoma City. The opening concluded a two-year $43 million construction and renovation project that was part of a $100 million construction project to consolidate pediatric and women's services in the new Children's Hospital, and adult services and the Trauma Center at Presbyterian Tower. The new Children's Hospital has all private rooms; a women's and newborn pavilion; 88-bed neonatal intensive care unit; a neonatal "village' where parents can room-in with their newborns; a 25-bed pediatric intensive care unit that provides the state's only acute care pediatric dialysis; an emergency department; pediatric stem cell transplant unit; pediatric catheterization lab; and, surgery and radiology departments.

Saint Francis Health System in Tulsa anticipates the completion in January 2008 of their new $72.6 million, 104-bed Children's Hospital. The new Children's Hospital will have specialized units for general pediatrics, oncology/hematology, pediatric surgery, pediatric intensive care and pediatric cardiology services. The hospital will also provide services including x-ray, computed tomography (CT) scan, pharmacy and outpatient and inpatient infusion therapies. Rooms for families to stay on-site with children in the intensive care unit will also be available. //2008//
/2009/ Rural ambulance service in Oklahoma has been a focus of ongoing concern with health care providers and the Legislature. Rural counties are losing residents yet still need emergency medical services available. Many ambulance services have been financially unable to continue operation. The Legislature did provide state funding toward relief with planning to continue on restructuring to a regional system.

In February 2008, the University of Oklahoma Regents approved plans for a $50 million gift from the George Kaiser Family to establish a School of Community Medicine in Tulsa. The goal, to improve the health status of underserved Oklahomans by producing doctors dedicated to that purpose. Funds will be used to recruit and hire new faculty members, scholarships and financial aid for medical students and residents and for startup and infrastructure. Students will be recruited and selected for the community medicine track when they are admitted to medical college. //2009//
/2010/ More cities across Oklahoma are including a fee for ambulance services in resident's monthly utility bills. Cities are finding this an effective way to support ambulance services and also free up funds for other services.

In May, Governor Henry signed SB 267 which allows Tobacco Settlement Endowment Trust funds to be used for capital expenditures and operating expenses incurred by the University of Oklahoma Health Sciences Center and Oklahoma State University College of Osteopathic Medicine for educational programs and residency training. This measure will help assure that the medical schools are stable and is seen as a critical step in addressing the physician shortage in Oklahoma. //2010//

Discussion is currently underway between the OHCA, the OKDHS and the OSDH regarding Medicaid expansion of health coverage for uninsured and underinsured pregnant women under the State Children's Health Insurance Program (SCHIP). This expansion would allow Medicaid to cover services for these pregnant women for the benefit of the health of the unborn child. Currently these women are receiving their health care primarily through the statewide county health department system which includes contracted services through community clinics in Oklahoma and Tulsa counties; the University of Oklahoma and Oklahoma State University's teaching environments (clinical and hospital); and, the state's federally qualified community health centers (FQHCs).
/2007/ The OHCA, the OKDHS and the OSDH continue to work collaboratively on strategies to address the perinatal health care system and will be exploring options that may be taken as a result of the Medicaid Reform Act passed this year. The OHCA and the OSDH (MCH) conducted six regional meetings across the state February through May with public and private perinatal health care providers, rural and urban, primary to tertiary, to gain information on ideas for changing Medicaid policy as well as state health
care systems to improve access and delivery of perinatal services. //2007//
/2008/ A Medicaid policy revision that would have provided the ability to offer prenatal care to women using the unborn child option under the SCHIP was not taken forward due to lack of support from the Legislature and Governor.

Other changes in Medicaid policy have occurred this year resulting from input received from the regional meetings held in the spring of 2006 and ongoing routine meetings of the OHCA/OSDH (MCH) Perinatal Advisory Task Force, an advisory group of medical providers, professional medical and nursing organizations and interested advocates that is co-chaired by the Chief of MCH. Ultrasound and other diagnostic benefits have been expanded, dental care benefits have been implemented and a psychosocial assessment has been developed and implemented. Policy changes for restructuring fees to allow for co-management of high risk maternity clients, coverage for licensed clinical social work services, and coverage for genetic counseling and certified lactation consultant services are being explored. An electronic application that will automatically add a newborn to its mother's existing SoonerCare (Medicaid) case is also being developed. This will facilitate provision of medical benefits to the newborn as the mother will leave the hospital with a printout showing the infant's full eligibility and assigned client identification number. The infant will receive a permanent client identification card through the mail in three to five days.

Abortion was a highly debated issue among the Legislature, Governor and health care providers. Governor Henry vetoed an anti-abortion bill prohibiting use of state funds and resources to perform abortions in the state. The Oklahoma State Medical Association and other professional medical and nursing groups also opposed this bill. A second bill, SB 139, will become law without the Governor's signature. Under the Oklahoma Constitution, a bill approved by the Legislature automatically becomes law after five days if the Governor declines to take action on it. SB 139 provides for exemptions for cases of rape and incest, and includes language that allows for a physician to discuss options with his or her patients, language not in the vetoed bill. Health care providers remain concerned that uninsured and underinsured women with troubled pregnancies will not receive medically qualified abortions. Of specific concern is the bill fails to provide exemptions for instances of a lethal birth defect. //2008//
//2009// Soon to be Sooners (STBS), a Medicaid policy revision that provides the ability to offer prenatal care to women using the unborn child option under the SCHIP, went into effect April 1, 2008. This allows all qualified women to receive prenatal benefits without respect to citizenship.

The electronic application (NB1) that will add a newborn to its mother's existing SoonerCare (Medicaid) case is being piloted. This change will facilitate the newborn having full Medicaid eligibility before being discharged from the hospital.

A law requiring that women receive an ultrasound prior to an abortion, SB 1878, passed in April 2008. The health provider must allow the mother to view the ultrasound if she chooses. //2009// ***/2010/ The NB1, the electronic application for newborns completed in the hospital, is being integrated into hospitals across the state. //2010//***

The public health system in Oklahoma includes the OSDH, county health departments in 67 of 77 counties with 87 service sites in these organized counties, and contract community providers. The city-county health departments in Oklahoma and Tulsa counties have their own personnel systems and are administratively separate from the state system. The remaining county health departments are administrative units of the OSDH. The CSHCN Program provides services in all 77 counties in the state. In addition, two medical schools are located in Oklahoma, one in Tulsa and the other in Oklahoma City, which also maintains a Tulsa campus. The College of Public Health within the University of Oklahoma Health Sciences Center (OUHSC) campus in Oklahoma City also contributes significantly to the advancement of public health in Oklahoma through its education and training programs.
/2007/ Oklahoma received $2,730,000 this year as part of a $14.7 million five-year award from the Substance Abuse and Mental Health Services Administration (SAMSHA). Through this cooperative agreement, the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) will provide leadership in facilitating the transformation of Oklahoma's mental health service delivery system into a system driven by consumer and family needs that focuses on building resilience and facilitating recovery. //2007//
/2009/ Oklahoma added an additional county health department to its organizational structure. Osage County residents are receiving services at a temporary location with plans to expand services when the new county health department is completed. //2009//

There are currently eight Federally Qualified Health Centers (FQHCs) in Oklahoma operating 17 access sites: Central Oklahoma Family Medical Center (Konawa); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest); Mary Mahoney Memorial Health Center (Langston, 2 Oklahoma City sites); Morton Comprehensive Health Services (Nowata, 3 Tulsa sites); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft. Cobb, Tipton); Northeastern Oklahoma Community Health Centers (Hulbert, Tahlequah, Muskogee); and, Stigler Health and Wellness Center (Stigler). During the 2005 legislative session, over two million dollars were appropriated to support existing FQHCs and expand Oklahoma FQHCs. Just over a million of these funds is to be used for the reimbursement of care provided to uninsured clients. Another million is to be used for enhancing and developing FQHCs in Oklahoma (e.g., contracting for grant writing services, providing transitional operational assistance for new FQHC organizations). Oklahoma also received $2.85 million this year for four new community health centers (Clayton, Fairfax, Idabel and Tulsa) from the Health Resources and Services Administration, Bureau of Primary Health Care.
/2007/ Federal and state funding currently supports 11 community health centers with 20 access sites across Oklahoma. Central Oklahoma Family Medical Center (Konawa); Mary Mahoney Memorial Health Center (2 Oklahoma City sites, Langston); Community Health Connections (Tulsa); Fairfax Medical Facilities (Fairfax); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest, Idabel); Morton Comprehensive Health Services (3 Tulsa sites, Nowata); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft Cobb, Tipton); Northeastern Oklahoma Community Health Services (Hulbert, Tahlequah); Stigler Health and Wellness Center (Stigler); and, Pushmataha Family Medical Center (Clayton). //2007//
/2008/ There has been no change in the number of community health centers and access sites this year. The Oklahoma Primary Care Association continues to work with multiple communities as steps are being taken for submission or resubmission of federal funding applications to support development or enhancement of service delivery systems in Oklahoma City, Lawton,

Alfalfa County, Sequoyah County and Tulsa. //2008//
/2009/ Federal and state funding currently supports 13 community health centers with 26 access sites across Oklahoma. Central Oklahoma Family Medical Center (Konawa); Great Salt Plains Health Center (Cherokee); Mary Mahoney Memorial Health Center (3 Oklahoma City sites, Langston); Community Health Connections (Tulsa); Fairfax Medical Facilities (Fairfax, Hominy); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest, Idabel); Morton Comprehensive Health Services (3 Tulsa sites, Nowata); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft Cobb, Tipton); Northeastern Oklahoma Community Health Services (Hulbert, Tahlequah); Lawton Community Health Center (Lawton); Stigler Health and Wellness Center (Stigler, Sallisaw, Eufala); and, Pushmataha Family Medical Center (Clayton). //2009//
/2010/ Oklahoma will receive $7.8 million for community health center grants from the federal stimulus package. The money will fund three new organizations and the operation of six new sites. Oklahoma community health centers served more than 107,000 patients in 2007 with nearly 50% reported as uninsured. It is anticipated that the additional funds will provide for 40,000 additional individuals to be served. //2010//

Native Americans are increasing their visibility related to investments being made toward improving Oklahoma's health. Newspaper stories and paid television spots depict the services and changes occurring. Access to health care for tribal members in the rural areas of the state is through tribe specific health facilities. Intertribal urban clinic facilities are found in Tulsa and Oklahoma City and hospitals operated by Indian Health Services are located in Claremore, Tahlequah and Lawton.

Given the changing culture, economics, political climate and health care systems in Oklahoma, creative and flexible prevention and intervention approaches are required to adequately address the health needs of the maternal and child health population. Maternal and child health leaders and other state health leaders are continuously challenged to enhance existing health systems to assure a comprehensive quality system of health care. Ongoing collaborative partnerships are key to their success.

B. Agency Capacity

Under the provisions of Public Law 97-35, Section 509(b), the OSDH and the OKDHS share the administration of the Oklahoma Title V Program. Administration of services to women, infants, children and adolescents is provided by the OSDH through MCH. Administration of services to children with special health care needs is administered by the OKDHS. Since the Omnibus Budget Reconciliation Act (OBRA) of 1981, the OKDHS has received its designated portion of the Title V monies to operate the CSHCN Program. The statutory authority which designates the OKDHS to operate the CSHCN Program is covered in Title 10 of the Oklahoma Statutes 1981, Section 175.1 et. seq. and article XXV of the Oklahoma Constitution.

The OSDH and the OKDHS collaborate to administer the CSHCN Program through a memorandum of agreement. This memorandum of agreement outlines the relationship between the two agencies to include responsibilities for the Title V Block Grant annual report and application. Copies of the memorandum of agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.
/2007/ The memorandum of agreement between the OSDH and the OKDHS is reviewed annually, edited as mutually agreed upon by both agencies and signed by the Commissioner of Health and the Director of the OKDHS. A copy of this year's agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. //2007//
/2008/ The memorandum of agreement between the OSDH and OKDHS for the 2008 grant period has been signed and is on file in MCH Administration. A copy of this year's memorandum of agreement is attached. Copies of the signed agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. //2008//
/2009/ The memorandum of agreement for 2009 has been signed with both MCH and CSCHN

maintaining a copy of the agreement on file. A copy of the agreement is attached. Electronic or hard copy is available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. //2009//
/2010/ Based on a recommendation from the federal team review of the Title V MCH Block Grant Application in August 2008, the memorandum of agreement between the OSDH and the OKDHS was revised this year to be a multi-year agreement, October 1, 2009-September 30, 2012. A copy of the agreement is attached. //2010//

MCH and CSHCN schedule monthly meetings to plan and coordinate activities. During these meetings, staff share updates on services and collaborate on strategies to improve services. In addition, these meetings provide the opportunity to coordinate activities in preparing the Title V Block Grant for submission. MCH coordinates the compilation of all MCH and CSHCN information for submission of the needs assessment, annual report and application with CSHCN providing MCH with its written responses to be incorporated into each of the grant areas. These meetings also provide a forum to engage other OSDH programs such as Newborn Metabolic Screening, Genetics, Early Intervention (SoonerStart), Dental Health and the Women, Infants and Children Supplemental Nutrition Program (WIC) in discussions and collaborative planning.
/2009/ MCH and CSHCN have rescheduled these planning meetings and now meet every other month. In the past year, staff from the Oklahoma Family Network (OFN) have been engaged in these meetings and provide input from the parent and family perspective. //2009//
/2010/ With the comprehensive needs assessment in process for the 2011 Title V MCH Block Grant application, MCH, CSHCN and OFN have moved back to meeting monthly to assure continuous coordination of activities. //2010//

MCH partners with all Services in the Family Health Services (FHS): Child Guidance; Screening, Special Services and SoonerStart; Family Support and Prevention; Dental Health; and, WIC. MCH funds directly support services provided by Dental Health Service (statewide dental needs assessment of third grade children in public schools, community-based dental clinics and dental health education) and Screening, Special Services and SoonerStart (newborn metabolic and hearing screening, and birth defects registry).
/2007/ Additional MCH funds are being prioritized to maintain critical infrastructure services in newborn metabolic and hearing screening due to reductions in other federal funding sources. //2007//

MCH maintains a strong relationship with the OSDH Community Health Services (CHS). The CHS receives MCH funds for direct, enabling, population-based and infrastructure services delivered through the statewide county health department system. The county health department system consists of 67 county health departments with 87 service sites. Monthly meetings occur between MCH and the CHS to coordinate budget and health care service issues that arise.
/2009/ With the addition of a county health department in Osage County, there are now 68 of 77 counties with county health departments increasing services sites to 88. //2009//

MCH works closely with all areas within the OSDH. The Commissioner of Health facilitates a monthly Executive Team Meeting that all Deputy Commissioners, Service Chiefs and Program Directors are invited to attend. This meeting provides an opportunity for agency updates, sharing of program activities, asking of questions and informal networking. MCH also participates on key agency committees and work groups that focus on data systems, analysis, and utilization; retention of personnel; personnel budgeting; cultural respect; agency forms; and, compliance with the Health Insurance Portability and Accountability Act (HIPAA). The Deputy Commissioner of the FHS has two meetings a month with Chiefs of all Services administratively organized under the larger FHS. These meetings provide the opportunity for the Chief of MCH to interact with all Chiefs in FHS and to discuss collaborative activities. MCH works closely with FHS Services on health issues such as dental care of mothers and children, nutrition, childhood obesity, injury prevention, newborn hearing screening, newborn metabolic screening, genetics, prevention of birth defects, teen pregnancy prevention, school health, family resource and support services, child care and early childhood.

In addition to ongoing collaborative activities and meetings throughout the year, MCH facilitates annual meetings each year with the CHS, Dental Health Service, Public Health Laboratory and Screening, Special Services and SoonerStart to discuss activities to be accomplished in the next state fiscal year and budgeting of Title V MCH funds within these Services' budgets to support planned activities. These meetings occur in the spring of each year to better coordinate establishment of annual state fiscal year budgets (July 1 - June 30).

Services for the maternal and child health population are also accomplished through professional service agreements (e.g., physician, nurse practitioner), vendor contracts (e.g., ultrasounds, supplies), contracts with other state governmental agencies, requests for proposals (RFPs) and invitations to bid (ITBs). Oklahoma City County Health Department and Tulsa City County Health Department, who are administratively separate from the OSDH, are key providers of MCH services in the two large metropolitan areas through direct contracts. Other community-based providers provide MCH services through professional service agreements or the ITB process. /2007/ To enhance the capacity of the OSDH to provide culturally appropriate services, the OSDH requires that each OSDH employee complete a minimum of 3 hours of training on cultural competency/respect each year as part of each employee's annual Performance Management Process (PMP). In addition, the OSDH Office of Minority Health provides leadership in collaboration with the Oklahoma State University and the University of Oklahoma Medical Center in the provision of the Health Service Interpreter Certification Program available to public and private health care providers across the state. This training, implemented in early federal fiscal year (FFY) 2006, is the first ever certified interpreter program in Oklahoma. It consists of 20 hours of direct contact instruction in language and cultural aspects of communication, followed by a written exam in English and a verbal exam in the target language selected. The training covers medically specific terminology, linguistic accuracy, legal and ethical role of health service interpreters, client safety and HIPAA regulations on confidentiality. //2007//
/2010/ Interpreter training for OSDH state office and county employees is now offered directly through the OSDH Office of Minority Health. //2010//

CSHCN oversees the provision of services to children receiving SSI within the state by providing training and guidance to the 45 social services specialists located in OKDHS county offices across the state. These social services specialists are responsible for writing and monitoring services plans for all SSI children who receive benefits through the OKDHS. All equipment and services available through Title V CSHCN must be pre-approved by the state office. /2007/ The OKDHS now has 77 social services specialists across the state who complete and monitor service plans and oversee the provision of services to children who receive SSI and Medicaid. Families of children who receive SSI but do not receive Medicaid are also contacted to assure they are informed of services available through CSHCN. //2007//

CSHCN initiates and monitors professional service contracts with clinics that provide care to neonates in the Tulsa and Oklahoma City metropolitan areas. CSHCN also contracts with physicians for provision of psychiatric services to children in OKDHS custody. In addition to contracting with a respite care facility, the state's referral and resource network for CSHCN, and a program that provides integrated community-based services for CSHCN, CSHCN also meets with these contractors at least quarterly to ensure CSHCN goals are being met through these contracts. CSHCN also has a representative on numerous parent advocate groups for CSHCN throughout the state and attends their meetings at least every other month. /2007/ CSHCN funds a parent advocate position in one of the neonate clinics and will be providing funding to the Developmental Disabilities Services Division (DDSD) within the OKDHS this year to support a family network which trains and certifies individuals to be mentors to families of children with autism. //2007//

An attachment is included in this section.

C. Organizational Structure

In Oklahoma, state health and human services are loosely organized under the Cabinet Secretary of Health and the Cabinet Secretary of Human Services who are appointed by the Governor. Terry Cline, Commissioner of the DMHSAS, is the Cabinet Secretary of Health and Howard Hendrick, Director of the OKDHS, is the Cabinet Secretary of Human Services. Health and human services agencies in Oklahoma include the OSDH, OKDHS, DMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA and Oklahoma Commission on Children and Youth. The Department of Corrections and the OSDE are under different cabinet secretaries. The Oklahoma Commission on Children and Youth is charged with planning and coordinating children's services in the state in addition to providing oversight for juvenile services. The agency heads of all the major agencies serving children are appointed to serve on the Oklahoma Commission on Children and Youth.

Oklahoma administers the Title V Program through two state agencies, the OSDH and the OKDHS. The OSDH, as the state health agency, is authorized to receive and disburse the Title V MCH Block Grant Funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections create the OSDH, charge the Commissioner of Health to serve under the Board of Health and outline the Commissioner of Health's duties as "general supervision of the health of citizens of the state." Title 10 of the Oklahoma Statutes, Section 175.1 et.seq. grants the authority to administer the CSHCN Program to the OKDHS.

The Title V MCH Program is located in the OSDH within the FHS. The FHS is organizationally placed under the Commissioner of Health. Suzanna Dooley, M.S., A.R.N.P., Chief of MCH, is directly responsible to the Deputy Commissioner of the FHS, Edd Rhoades, M.D., M.P.H., who is directly responsible to the Commissioner of Health, James M. Crutcher, M.D., M.P.H. Organizational charts of the OSDH, the FHS and MCH are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

The Title V CSHCN Program is located in the OKDHS within the Health Related and Medical Services (HRMS). The HRMS is organizationally placed under the Family Support Services Division. Karen Hylton, B.A., is the Director of the CSHCN Program and Program Manager for the HRMS. Karen Hylton is directly responsible to Jim Struby, B.A., Programs Administrator. Jim Struby is directly responsible to Mary Stalnaker, M.S.W., Family Support Services Division Director. Mary Stalnaker is directly responsible to Farilyn Ballard, M.S.W., Chief Operating Officer Human Service Centers who is directly responsible to the Director of the OKDHS, Howard Hendrick, J.D. Organizational charts of the OKDHS, Family Support Services Division, HRMS and CSHCN Program are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.
/2007/ Organizational charts are attached. There have been no changes in agency structures. //2007//
/2008/ Terry Cline, PhD, resigned as Oklahoma Cabinet Secretary of Health and Commissioner of the Oklahoma DMHSAS and accepted the position of Administrator for SAMHSA. Dr. Cline was nominated by President George W. Bush on November 13, 2006 and confirmed by the U.S. Senate on December 9, 2006. In February 2007, Governor Brad Henry appointed the OSDH Commissioner of Health, James M. Crutcher, M.D., M.P.H., as the new Cabinet Secretary of Health.

Organizational structure of the OSDH changed in October 2006 with Rocky McElvany, M.P.H., named Chief Operating Officer. This position assists the Commissioner of Health with day-to-day organizational executive issues and complex administrative issues; advises the Commissioner of Health on health planning, policy analysis and agency opportunities; and, represents the Commissioner of Health and OSDH as needed. Organizational charts of the OSDH and the FHS are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. The MCH organizational chart is attached.

Farilyn Ballard, OKDHS Chief Operating Officer for the Human Services Centers, retired and was replaced by Marq Youngblood, MHR. Organizational charts of the OKDHS, Family Support Services Division and HRMS are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. The CSHCN organizational chart is attached. //2008// /2009/ There have been no changes to agency structures. Organizational charts of the OSDH and the OKDHS are on file in MCH Administration with electronic or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. MCH and CSHCN organizational charts are attached. //2009//
/2010/ Dr. Crutcher retired as the Cabinet Secretary of Health and the OSDH Commissioner of Health just after the beginning of 2009. The Governor appointed Terry White, MSW, Commissioner of Oklahoma DMHSAS, to be Cabinet Secretary of Health. Terry White is the first woman to serve as Secretary of Health since the executive cabinet system was created in the 1980s. The OSDH Board of Health hired Terry Cline, PhD, as the new Commissioner of Health. Rocky McElvany, Chief Operating Officer, assumed responsibility as Interim Commissioner of Health until Dr. Cline began his new role with the OSDH on June 30. Dr. Cline, previously the Oklahoma Cabinet Secretary of Health and Commissioner of the Oklahoma DMHSAS, returns to Oklahoma after leaving in late 2006 to serve in a federal role as the Administrator for SAMSHA. Most recently, Dr. Cline served as Health Attaché at the U.S. Embassy in Baghdad, Iraq. Organizational charts of the OSDH, MCH, OKDHS and CSHCN are on file in MCH Administration with electronic or hard copy available by contacting (405) 271-4480 or e-mail at paulaw@health.ok.gov. //2010//

D. Other MCH Capacity

MCH consists of MCH Administration and three Divisions: Child and Adolescent Health, Women's Health and MCH Assessment. MCH Administration consists of Service level administrative support staff as well as the Public Health Social Work Coordinator, MCH Nutrition Consultant and MCH Family Advocate who work across all MCH programs. The Child and Adolescent Health Division staff are primarily nurses and health educators. Programs and services include child health clinical services, school health, adolescent health, early childhood, child care, suicide prevention, teen pregnancy prevention and injury prevention. The Women's Health Division staff are nurses, nurse practitioners and health educators. Programs and services include maternity, family planning and preventive health education services for females and males of reproductive age. MCH Assessment staff are epidemiologists, biostatisticians and program analysts. These staff evaluate MCH programs and services. MCH Assessment staff are also responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Middle School Risk Behavior Survey, the

Oklahoma Fifth Grade Health Survey and the Oklahoma First Grade Health Survey.
/2007/ The MCH Family Advocate position was renamed MCH Family Specialist. With the resignation of this staff person in December, MCH has taken the opportunity to explore with other programs in the FHS and state partners options for restructuring the position. Based on input received, two half-time positions are being established as Family Specialists. The parents in these positions will not only be a resource to MCH but to all FHS programs and other state partners, as needed, participating in development, implementation and evaluation of state policy and services for the maternal and child health population. //2007//
/2008/ MCH has been unsuccessful in recruiting parents into the part-time Family Specialist positions. Discussions with family organizations have led MCH to reconsider these positions and to explore alternative ways of using these funds to support involvement of parents/guardians involved with Oklahoma family organizations in MCH planning and services development. As indicated under Public Input, onsite technical assistance from Family Voices Inc. is being planned. This technical assistance will focus on identifying strategies to enhance family input in MCH and CSHCN activities. //2008//
/2009/ Technical assistance was received from Family Voices Inc., on September 25, 2007. A specific strategy resulting from the technical assistance was the planning and presenting of a family/professional partnerships conference, Joining Forces: Supporting Family/Professional Partnerships, in Oklahoma City on April 26, 2008. This conference provided families and state professionals with information on the importance of family/professional partnerships to help increase family participation in development, implementation and evaluation of state programs serving MCH (inclusive of CSHCN) populations. MCH and CSHCN linked with additional families and family organizations during this conference and plan to utilize these resources in program planning and evaluation activities. //2009//
/2010/ In October 2008, the Women's Health Division was renamed the Perinatal and Reproductive Health Division to more accurately reflect the scope of services provided to pregnant women, infants and reproductive age women and men. //2010//

Suzanna Dooley, M.S., A.R.N.P., is the Title V MCH Director and Chief of MCH. Beth Ramos, M.P.H., is the Director of the Child and Adolescent Health Division. Cedar Jackson, M.S., A.R.N.P., is the Director of the Women's Health Division. Dick Lorenz, M.S.P.H., is the Director of MCH Assessment. Jim Marks, M.S.W., Public Health Social Work Coordinator, Nancy Bacon, M.S., R.D./L.D., C.D.E., MCH Nutrition Consultant, Lyn Thoreson, MCH Family Advocate, and Paul Patrick, M.P.H., MCH Data Contact, are also part of MCH leadership. The Child and Adolescent Health Division is currently in the process of identifying a new medical director as the previous medical director resigned June 30, 2005 to pursue other interests. Pamela Miles, M.D., from the Department of Obstetrics and Gynecology, OUHSC campus, serves as the Medical Director to the Women's Health Division through a contractual agreement. Brief biographies of the leadership for MCH are attached.
/2007/ Beth Ramos, M.P.H., the Director of the Child and Adolescent Health Division passed away unexpectedly in October 2005. Suzanna Dooley, M.S., A.R.N.P., Title V MCH Director and Chief of MCH, has served as the Interim Director for the Child and Adolescent Health Division as staff have adjusted to the loss and decisions made as to refill of the position. A new Director is to be hired this summer. As previously indicated, the MCH Family Advocate position was renamed MCH Family Specialist. Lyn Thoreson resigned from this position in December 2005. As a result of exploring restructuring of the position, two half-time MCH Family Specialist positions have been established with plans to fill both positions this summer. Jim Marks, M.S.W., Public Health Social Work Coordinator, has resigned his position as of the end of July. The position is to be refilled this summer. Edd Rhoades, M.D., M.P.H., Deputy Commissioner of the FHS, is currently serving as the Medical Director for the Child and Adolescent Health Division. Brief biographies of the leadership for MCH are attached. //2007//
/2008/ August 1, 2006, Jim Marks, M.S.W., was hired as the Director of the Child and Adolescent Health Division. December 14, 2006, Margaret DeVault, M.S.W., was hired as the Public Health Social Work Coordinator. As previously indicated, the MCH Family Specialist positions have been reconsidered and MCH is now exploring use of the funds from these positions to support involvement of parents/guardians from Oklahoma family organizations in MCH planning and

service development activities. On June 22, 2007 Cedar Jackson, Director of the Women's Health Division, resigned to pursue other personal work goals. This position will be posted with the intent to refill this fall. There have been no other changes in MCH administrative structure. Brief biographies of the leadership for MCH are attached. //2008//
/2009/ Paul Patrick, MCH Data Contact, resigned September 2007. Dick Lorenz, Director, MCH Assessment assumed responsibilities as the MCH Data Contact during an interim period until Robert Feyerharm M.A., was hired as the MCH Senior Biostatistician in February 2008 and assumed this responsibility. Jill Nobles-Botkin, M.S.N., C.N.M., accepted the position of Director, Women's Health Division in March 2008. Alicia Lincoln M.S.W, M.S.P.H., began assisting with development of the Title V Block Grant Annual Report and Application. There have been no other changes. Brief biographies of the leadership for MCH are attached. //2009//
/2010/ Margaret DeVault, Public Health Social Work Coordinator, resigned September 2008. Julie Dillard, M.S.W., assumed responsibilities of this position June 8, 2009. After 35 years with the OSDH, Dick Lorenz, Director of MCH Assessment, retired April 1, 2009. This vacancy is approved for refill and currently posted on state and national organization websites. Brief biographies of key MCH staff are attached. //2010//

The MCH central office organizational chart currently shows 40 full time equivalent (FTE) positions of which 38 are currently funded for 2006. Of these, 27.05 positions are funded on Title V Block Grant funds with the remaining 10.95 positions funded on state and other federal grant funds.
/2007/ MCH currently has 41.5 FTE positions funded for state fiscal year (SFY) 2007. Title V funds 25.4 of these FTE with the remaining 16.1 FTE funded on other state and/or other federal funds. //2007//
/2008/ For SFY 2008, MCH has 41.75 FTE positions funded. Title V funds 26.65 of these FTE with the remaining 15.1 FTE funded on other state and/or federal funds. //2008//
/2009/ For SFY 2009, MCH has 41.6 FTE funded. Title V funds 24.95 of these FTE with the remaining 16.65 FTE funded on other state and/or federal funds. //2009//
/2010/ With budget deficits experienced this past year, MCH has made an administrative decision to not refill two FTE Administrative Assistance positions that vacated in SFY 2009 and to realign responsibilities of existing administrative support staff for SFY 2010. MCH will monitor the impact this decision has on organizational operation and, if needed, will look to realign budgets to fill one of the vacant positions. For SFY 2010, MCH has 39 FTE funded. Title V funds 24.05 of these FTE with the remaining 14.95 FTE funded on other state and/or federal funds. //2010//

The Chief of MCH has a routine planning meeting scheduled on Tuesday morning of each week with MCH Directors, the Public Health Social Work Coordinator, the MCH Nutrition Consultant, the MCH Family Advocate and other MCH staff as identified depending on the area(s) being addressed. These meetings assist MCH to accomplish activities related to setting of priorities and initiating plans of action. These meetings also provide a routine time for MCH to meet with other areas in the agency such as HIV/STD, Public Health Laboratory, Office of Primary Care and Turning Point as specific issues need to be addressed. On every other Monday morning, MCH has a routine staff meeting for all staff involved in MCH comprehensive program reviews. These meetings allow for development and revision of program review policy, procedure and tools as well as coordination of program review schedules. MCH also has a general staff meeting every other month that brings all MCH staff together for agency updates, training and Service-wide planning.
/2010/ MCH General Staff Meeting has moved to a quarterly schedule. Information needing to be shared between these meetings is accomplished through Division staff meetings scheduled twice a month or through MCH Service-wide e-mail communications. //2010//

Karen Hylton, B.A., Program Manager for HRMS, is the Title V CSHCN Director. Other state office staff includes Frank Gault, M.S.W., Programs Field Representative, Family Support Services Division and Mike Chapman, B.A., Supplemental Security Income-Disabled Children Program (SSI-DCP). Robert Brown, M.D., is the Medical Director for the OKDHS and also the

CSHCN Program. Brief biographies of the CSHCN Program leadership are attached.
/2007/ There have been no changes to staff for the CSHCN Program. Brief biographies are attached. //2007//
/2008/ Frank Gault retired this past year after 34 years of service with the OKDHS. He was replaced by John Johnson, MEd, who formerly supervised local OKDHS county staff who had responsibility for determining eligibility and providing case management for the aged, blind and disabled population, including children who receive SSI. Brief biographies of the leadership for CSHCN are attached. //2008//
/2009/ There have been no changes to staff for the CSHCN Program. Brief biographies are attached. //2009//
/2010/ Dr. Liphard d'Souza has assumed the position of Medical Director for the Developmental Disabilities Services Division of the OKDHS and has agreed to replace Dr. Brown as the Medical Director for the CSHCN Program. Brief biographies of key CSHCN staff are attached. //2010//

The system used by the OKDHS to track the number of FTE in the CSHCN Program is different than that used by the OSDH. No FTE within the OKDHS is totally funded by Title V. Approximately 48 FTE were involved with the CSHCN Program during the last fiscal year.
/2007/ The OKDHS now has over 70 FTE who work in county offices throughout the state and are responsible for ordering equipment and diapers provided through the SSI-DCP as well as ensuring any other needs that can be met through the CSHCN Program are provided. //2007//

CSHCN has parent involvement to include support for parent positions in various CSHCN programs (Oklahoma Areawide Services Information System (OASIS) parent coordinator - 1, OASIS staff - 5, Oklahoma Infant Transition Project - 1 and Tulsa Neonate Follow-up Clinic - 1).
/2007/ In addition to continuing to provide support for parent positions with the OASIS, the Oklahoma Infant Transition Project and the Tulsa Neonate Clinic, CSHCN also supports parent advocates through contracts with the OUHSC Autism Clinic and the Sooner SUCCESS Project at the OUHSC Child Study Center. //2007//
/2008/ CSHCN is contracting with the Oklahoma Family Network (OFN), a parent organization that provides mentoring services to other parents of children with special health care needs. Joni Bruce, Executive Director of OFN, was designated by MCH and CSHCN to be the fifth Oklahoma delegate to the Association of Maternal and Child Health Programs (AMCHP). //2008//
/2010/ The OFN received a Family-to-Family Health Information and Education Center grant from the MCHB this past year. Included in the new staff hired to carry out grant activities are a Native American Coordinator and a Latino Coordinator. //2010//

State office CSHCN staff meet at least weekly to discuss training needs, plan site visits and discuss CSHCN issues. Mike Chapman meets with field staff (either individually or collectively) at least monthly to provide training and discuss activities surrounding provision of services to children receiving SSI.

MCH and CSHCN meet monthly with the State Interagency Coordination Council, which was set up by Sooner SUCCESS, a CSHCN contractor. This Council consists of representatives from parent organizations, the Medical Home Program and other State agencies.

/2007/ The OASIS is the statewide toll free information and referral line for MCH and CSHCN (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday-Friday from 8:00 AM to 6:00 PM with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday. TDD/TTY services for the deaf are available and bilingual staff are available to Spanish speaking callers. The OASIS also maintains a website (http://oasis.ouhsc.edu/) for information and referral services. //2007//
/2010/ MCH and CSHCN, with input from the OFN, explored the potential of using Oklahoma 211 as the statewide toll free information and referral resource. Given 211's current regional structure (all private nonprofits with no centralized system at this time)

plus each regional 211 relying on the OASIS as their primary information and referral resource for MCH populations, to include CSHCN, the decision has been made to maintain the relationship and support of the OASIS. //2010//

An attachment is included in this section.

E. State Agency Coordination

The OSDH and the OKDHS coordinate closely with other State health and human services agencies. The Commissioner of Health and the Director of the OKDHS coordinate state planning and activities for shared priorities on a regular basis with Directors of other state agencies. Meetings occur more frequently at particular times of the year, such as when the State legislature is in session, than at other times of the year.

The OSDH and the OKDHS enjoy a particularly close and supportive relationship with the OHCA, the state Medicaid agency. These relationships have been instrumental in facilitating the development and implementation of services to benefit the MCH populations (e.g., breast and cervical cancer treatment, family planning waiver, TEFRA). Staff from the three agencies work together daily using each other's expertise as resources. Communication is continuous with input openly sought from each of the agencies as they accomplish their responsibilities. //2008// The OSDH will continue to work with the OHCA this coming year as the OHCA changes Medicaid policy to move the OSDH from a clinic provider type to a public health provider type, a more appropriate designation for services of the OSDH. The Chief of MCH has been involved in these meetings and will continue to have the opportunity to provide input as this change continues.

The OHCA/OSDH (MCH) Perinatal Advisory Task Force, initiated in May 2005, has seen several accomplishments during this current grant period as a result of ongoing input received from health care providers, professional medical and nursing organizations, advocates and family representatives. Medicaid policy had been changed to include expansion of ultrasound and other diagnostic testing benefits, provision of dental benefits and development and reimbursement of a psychosocial assessment. The task force will continue to meet through the next year as additional changes to improve perinatal services are explored. These meetings will occur every odd numbered month on the third Tuesday from 5 p.m. to 7 p.m. at the OHCA. The Chief of MCH co-chairs this task force.

With the success of the OHCA/OSDH (MCH) Perinatal Advisory Task Force, the OHCA Director of Child Health and the Chief of MCH, with support from leadership of the two state agencies, initiated a Child Health Advisory Task Force in February 2007. The task force meets the third Tuesday of every even numbered month from 5 p.m. to 7 p.m. at the OHCA. Members of the Child Health Advisory Task Force include representatives from the two university medical centers; state medical, nursing and other health care associations; Head Start; Smart Start Oklahoma; family organizations; and, other state health and human services organizations. Seven priority topics have been identified by task force members for focus: utilization of primary care; mental health; obesity; reimbursement structure; oral health; immunizations; and, accessing specialty care.

A multi-year (2004-2010) memorandum of agreement between the OSDE and OSDH provides for a collaborative relationship in facilitating the development and implementation of a comprehensive school health program in Oklahoma. Examples of activities include development of state level standards and protocols, provision of consultation and technical assistance to local school districts and school nurses and collection of data. Currently an orientation manual for new school health nurses is being finalized. MCH is also working with the OSDE to develop a training manual for school fitness testing and a database for local public schools to enter school fitness data into for use by the local school and in aggregate form by the state. //2008// /2009/ Changes to Medicaid facilitated through work of the OHCA/OSDH Perinatal Advisory Task

Force have included reimbursement for certified lactation consultants and policy changes to the Medicaid reimbursement structure to facilitate co-management of high-risk prenatal clients (e.g., community-based family practice or obstetric physician collaboratively managing client care with a physician specialized in maternal-fetal medicine at a tertiary center).

MCH supported travel to Oklahoma March 18-19 of the Medical Director, Curtis L. Lowery M.D., and Program Director, Tina Benton B.S.N., R.N., of the Arkansas ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System) Program to provide an overview of this program and consultation to the Perinatal Advisory Task Force members on next steps to consider in developing similar components in Oklahoma. As a result of the visit, the Perinatal Advisory Task Force formed two workgroups, one to explore implementation of standard perinatal guidelines and the other to explore expansion of telemedicine. MCH and OHCA staff are planning a trip to Arkansas in late July to observe the ANGEL Program.

The OHCA/OSDH Child Health Advisory Task Force has met routinely every other month with a focus on exploring efforts to increase the number of children with Medicaid having routine health check-ups. A related priority topic is looking at strategies to increase the number of young children receiving lead screening.

The OSDH has been collaborating closely with the OHCA on a multi-year grant received by the OHCA from the Centers for Medicare and Medicaid Services (CMS) to transform Oklahoma's Medicaid procedure to apply for and establish Medicaid eligibility. The focus is to establish an online enrollment process that allows members or potential members of SoonerCare to apply and receive eligibility electronically. Changes are expected to eliminate many of the barriers that prevent potential members from applying for coverage by: increasing access to and enrollment in SoonerCare coverage by creating an online enrollment process; reducing stigma associated with obtaining and completing SoonerCare applications; improving the availability of hours a potential member can access and complete the SoonerCare application; and, reducing the amount of time required to complete and submit the SoonerCare application, resulting in timelier eligibility determinations. Efficiency of the enrollment process will be increased through decreasing overall administrative costs associated with the current paper application process. In addition, data integrity and timeliness of reporting will improve.

Collaboration is ongoing with the OSDE regarding fitness testing. Senate Bill (SB) 519 was signed by Governor Brad Henry May 23 directing the OSDE and OSDH to facilitate development and implementation of a pilot in at least 15 elementary schools during the 2008-2009 school year.
//2009//
/2010/ MCH, the OHCA, the chairs of the OB/GYN departments for the University of Oklahoma and Oklahoma State University in Tulsa and staff from the teleconferencing department at the University of Oklahoma Health Sciences Center in Oklahoma City traveled to Arkansas in July 2008 to observe the ANGELS Program. The trip helped in the ability to facilitate discussions of the OHCA/OSDH Perinatal Advisory Task Force around quality improvement activities to improve Oklahoma's perinatal system.

In May 2009, the Perinatal Advisory Task Force members celebrated the end of four years of working together to improve health systems for Oklahoma's mothers and infants and moved into its fifth year with discussions on how to more effectively impact smoking rates of pregnant and postpartum women, ideas to decrease the number of late preterm births as well as c-sections and policy changes needed to formally implement the American Academy of Pediatrics classification of newborn nurseries.

The OHCA/OSDH Child Health Advisory Task Force entered its third year with members looking at how to more effectively reach out to families and link them with needed health services and insurance coverage, improve access to dental services and impact chronic diseases through preventive health services.

The two task forces provided input as Medicaid policy was changed to expand coverage of telemedicine services and first steps in transitioning from a paper application process for Medicaid coverage to an electronic system were implemented. Having dealt with numerous changes in Medicaid policy since their inception, the task forces are now beginning discussions that go beyond Medicaid to the larger health systems issues.

Delays were experienced in implementing the pilot project in 15 elementary schools for fitness testing due to budget constraints and state purchasing procedures. It is anticipated that the OSDH and OSDE will begin the pilots in the 2009-2010 school year. //2010//

Another close relationship is with the University of Oklahoma, particularly the OUHSC campus. The OSDH, as the state's public health agency, actively participates in activities of the OUHSC and vice versa. The OSDH provides opportunities for students to complete clinical rotations, internships and preceptorships. Joint educational activities such as classroom instruction, grand rounds, conferences and clinical training are accomplished in collaboration with the Department of Obstetrics and Gynecology, Department of Pediatrics, College of Public Health, School of Nursing, Child Study Center and College of Dentistry. The Department of Pediatrics and University of Oklahoma (OU) Physicians are key partners in supporting the SAFE KIDS Oklahoma, a state level coalition focused on prevention of childhood injuries. The College of Public Health works with the OSDH to facilitate accomplishment of Public Health Certificates and/or Master and Doctorate of Public Health Degrees for OSDH staff both at the state and local levels.
/2007/ The OSDH and the OUHSC College of Medicine have partnered to provide medical students the opportunity to gain public health experience. Beginning in the summer of 2005 and continuing this summer, medical students between their first and second year of medical school, who have an interest in learning more about public health, apply and are selected for summer employment at the OSDH. The medical students are matched with program areas of interest. The Chief of MCH has mentored a medical student each of these years. //2007//
/2009/ A medical student began with MCH June 2 and will work through the end of July. The student will assist with activities focused on reduction of infant mortality, safe sleep and mystery calling, a quality improvement activity of the family planning program. //2009//
/2010/ OSDH budget shortfalls prohibited having funding available to provide paid summer employment to medical students this year. //2010//

In addition to OU, the OSDH and the OKDHS link with colleges and universities across the state to provide students seeking health and human services related degrees with hands-on learning experience. For each experience, a formal written agreement with goals and objectives for the experience and evaluation of the student's progress are outlined between the faculty, agency staff and student. Students complete assignments by working side-by-side with county and/or state office staff.

The Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND) Program at the OUHSC Child Study Center receives support from both state agencies. The OSDH and the OKDHS along with other health and human services state agencies participate in planning meetings and provision of practicum experiences. The MCH Family Advocate is an Oklahoma LEND Family Mentor and assures students gain exposure to the issues faced by families in accessing and maintaining needed services for a child with special needs.
/2007/ The MCH Family Specialists will be linked with the Oklahoma LEND Program once hired. //2007//
/2008/ As indicated previously, MCH has been unsuccessful in recruiting for the part-time Family Specialist positions and has been exploring with family representatives of other organizations alternative ways to support involvement of parents/guardians in MCH planning and services development. The parent on staff with the Oklahoma Lend Program is one of the family representatives providing input to MCH and will be participating as part of the technical assistance visit being planned with Family Voices, Inc. //2008//

/2009/ As a result of the technical assistance received from Family Voices, Inc., in September 2007, the Joining Forces: Supporting Family/Professional Partnership Conference was held in Oklahoma City on April 26, 2008. The conference was a first step in development of a statewide network of families who are interested in partnering with state agencies and organization to provide input on the development, implementation and evaluation of programs. The conference presented the opportunity for state agencies/organizations and families to learn from each other and to link with one another based on needs and interests. //2009//
/2010/ The second annual Joining Forces Conference was held April 25, 2009. One hundred and nineteen individuals attended with half of that number (60) being family members representing 17 family organizations. Staff representing seven State agencies engaged in training and discussions with family members on how to better integrate family input into development, provision and evaluation of services. //2010//

Early childhood is a priority area of the state for which both agencies are providing leadership through collaborative partnerships. Through support of the Oklahoma Partnership for School Readiness (OPSR), a legislatively established public-private partnership, Oklahoma is finalizing a state plan for early childhood to be implemented in SFY 2006. Partnerships with the OSDE, Head Start, local 4-year old programs and child care providers are facilitating establishment of full day kindergarten, early Head Start programs and improved requirements and guidelines for licensed child care facilities.
/2007/ The state plan for early childhood developed with support from a Maternal and Child Health Bureau (MCHB), Community Integrated Services System (CISS) Grant was implemented this year. The outcomes for the state plan are: a statewide comprehensive and coordinated system of early childhood services that meets the needs of families with young children; families nurture, teach and provide for their young children; children will be born healthy and remain healthy; and, families with young children are able to find and afford high-quality care and education programs. //2007//
/2009/ The Early Comprehensive Childhood Systems (ECCS) Grant entered its third year of activities. The grant continues to provide critical infrastructure support to state and community-based activities. Eighteen Smart Start community-based initiatives are currently active. Plans to expand to additional communities have been hindered by anticipated state budget deficits. Private funding is being explored. //2009//
/2010/ The ECCS Grant is beginning the first year of the continuation funding. Support of local Smart Start community-based initiatives will be reduced this year with the ECCS grant funds being reduced by 25%. The remaining grant funds will continue to provide infrastructure support for a public/private partnership for statewide and community-based activities of the recently revised Oklahoma Early Childhood Comprehensive State Plan. The OPSR is now also the Early Childhood Advisory Council for Oklahoma. //2010//

Joint activities are accomplished with state medical and nursing associations. These include initiatives to impact the health status of Oklahomans; planning for and evaluation of health services; publishing of data and corresponding recommendations for health systems improvement; and, training and education presentations.

The Oklahoma Hospital Association provides critical linkage and credibility to activities needing to be accomplished with hospitals across the state. This relationship has assisted with implementation of important services such as statewide newborn hearing screening; evaluation and restructuring of the emergency medical system; and, state preparedness in the event of a natural or planned disaster.

The OSDH and the OKDHS work closely with FQHCs and tribal health care facilities to assure access to health care services. County health departments and local OKDHS offices work with these providers to link clients with needed services not available through the OSDH and the OKDHS. These partners are central to assuring access to primary care services, particularly for the uninsured and underinsured populations. Support of the Oklahoma Primary Care Association and the OSDH Office of Primary Care's efforts to expand FQHCs in Oklahoma is a priority.

/2007/ MCH has been invited and is participating in the quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board. In addition, MCH has also been invited and is having staff from MCH Assessment participate in the routine meetings of the Indian Health Services (IHS) Epidemiology Center Advisory Council. //2007//
/2009/ PRAMS collaborated with staff from the Southern Plains Intertribal Epidemiology Center and Oklahoma City Area Indian Health Service to write a PRAMSGRAM on Native American Perinatal Health Disparities. The news release from this PRAMSGRAM created several articles in print and online media sources, in both mainstream media and Native American media sources. As a result PRAMS and IHS staff were asked to present the findings at the American College of Obstetrics and Gynecology Oklahoma City Area Indian Health Service Team Meeting in June 2008. //2009//
/2010/ Tribal representation has been important as activities of the Commissioner's Action Team on Reduction of Infant Mortality have expanded. Leads for the Preconception and Interconception Care and Education, Breastfeeding, Safe Sleep and Tobacco workgroups have been the first to seek out and engage tribal involvement in their activities. //2010//

The OSDH and the OKDHS are two of 11 state agencies and programs participating in the Joint Oklahoma Information Network (JOIN), a data-sharing project with goals of helping state agencies provide services more efficiently and helping Oklahomans find community resources and programs and determine their eligibility for them. It is available at www.join.ok.gov. Other participating organizations include the OHCA, Oklahoma Commission on Children and Youth, Office of Juvenile Affairs, OSDE, Oklahoma Employment Security Commission, Oklahoma State Finance Office, Oklahoma Commerce Department, Oklahoma Rehabilitation Department and DMHSAS. The JOIN is being developed in phases. The first phase, a statewide information and referral system/resource database, is active. The second phase, a de-identified aggregate database for research, service planning and quality assessment is currently being compiled. The third phase, individual client information for single point of entry and case management, is in the planning stage.
/2007/ The JOIN website now includes an Eligibility Questionnaire to assist individuals and families in identifying government services for which they may be eligible to receive by answering a few questions. //2007//
/2008/ JOIN completed a pilot project matching client data across six participating agencies in the spring of 2007. Analysis included the number of persons served by multiple agencies and a special analysis focused on pregnant female clients. //2008//
/2009/ JOIN now includes a total of 14 participating agencies that in addition to those listed previously include the OK Department of Mental Health and Substance Abuse Services, OK Department of Corrections, and the University of Oklahoma Health Sciences and Infectious Diseases. The Web-Enabled Data Repository has been in pilot mode since inception in 2000. The application is web-based and written in IBM's Visual Age Java. The user administration piece is written as a Windows thick client running on a DB2 database. The OCCY has engaged a consultant to provide project management and IT technical support services in finalizing and deploying the JOIN application. The intent is to convert the existing DB2 database to either a Microsoft SQL or Oracle database. Once converted, the contractor will then develop a new user interface using either Microsoft .net or Oracle Forms and Reports. The next step will be to automate the transfer of data from the various end users to the JOIN database. The contactor will then develop the standardized reports users may require from the JOIN system. //2009//
/2010/ Work to convert the JOIN client services database to Microsoft SQL has been completed. Development of a new user interface using Microsoft.net should be completed by December 2009. Transfer of data from various agency end users to the JOIN data repository is being initiated. //2010//

F. Health Systems Capacity Indicators

Introduction

See Forms 17, 18 and 19.

Data are received from multiple sources for these indicators: the OSDH Center for Health Care Information, the OHCA, the PRAMS, the OKDHS and national data sets. Examples of data used are vital statistics, Medicaid enrollee data, Medicaid claims data, SCHIP enrollee data, SCHIP claims data and census data.

The OSDH continues to develop its Public Health Oklahoma Client Information System (PHOCIS). This system provides clinical information on maternity, child health and family planning clients and services. Modules continue to be refined for enabling, population-based and infrastructure services. This system has a link with the Oklahoma State Immunization Information System (OSIIS), the immunization statewide registry, and WIC, the supplemental nutrition program for women, infants and children.

With the improved data, retrieval is more complex because the focus has been on ease of documentation and on the collection of funds. The Health Insurance Portability and Accountability Act (HIPAA) has been used inappropriately to prevent data from being used for legitimate research purposes. Fear sustained from the World Trade Center attack has also negatively affected data access and utilization. Staff time is limited for analyzing all of the information in-depth; the epidemiologic and analytic staff must focus on specific measures, develop extraction methods for those specific data, and monitor and interpret the results of those measures.
/2009/OSDH has begun the linking process with Medicaid data. //2009//
/2010/ MCH has utilized the linked records to compare the maternal health, demographic characteristics and pregnancy outcomes of women who delivered on Medicaid with women who were covered by private insurance. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.2	34.2	33.7	37.2	37.2
Numerator	1156	857	858	971	971
Denominator	234935	250522	254718	260901	260901
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Sources: 2008 data is not yet available. 2007 discharge data from Health Care Information, OSDH used for numerator, U.S. Census Bureau 2007 population estimate for denominator.

Notes - 2007
Sources: No. of discharges in 2007 from Health Care Information, OSDH used for numerator, U.S. Census Bureau 2007 population estimate for denominator.

Notes - 2006
Sources: No. of discharges in 2006 from Health Care Information, OSDH used for numerator, U.S. Census Bureau 2006 population estimate for denominator.

Narrative:

Data used to track HSCI #01 are obtained from the OSDH Center for Health Statistics, Health Care Information (HCI) and its hospital discharge dataset. Typically, a formal request, submitted via email, is sent to the analyst responsible for the hospital discharge database. Response to the request is timely. MCH does not have routine access to raw electronic data; rather, data are provided in summary form to be incorporated into the Title V MCH Block Grant. The Health Care Information Advisory Committee determines access to the data, and many of the non-OSDH representatives have strongly supported the perspective that such data could be inflammatory and thus detrimental to the state's hospital system. The resulting lack of access to raw data prohibits detailed examination and understanding of the particularities of the data. Any concerns or questions regarding data quality or reliability are submitted to the analyst of hospital discharge data for comment. In addition, the Director of the OSDH Center for Health Statistics takes a strongly conservative position regarding the release of health information, even if assurances can be documented that the information will remain in aggregate form and never identify an individual. /2009/ No changes to the HCI policy. //2009//
/2010/ There has been no change to the HCI policy. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	84.1	85.8	88.4	87.9	88.7
Numerator	28666	30192	31690	33539	33161
Denominator	34074	35197	35862	38156	37389
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: OHCA CMS-416 EPSDT report, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Notes - 2006
Source: Oklahoma Health Care Authority.

Narrative:
Medicaid data are obtained through an indirect channel. Requests for data are sent through the OSDH Chief of the Office of Federal Funds Development, who serves as the liaison for data sharing between the OSDH and the OHCA, the State's Medicaid agency. This arrangement for communication has both advantages and limitations. To cite one benefit, it ensures that requests to OHCA for data are transmitted through a single point of contact, therefore, limiting the potential for scattershot requests coming from multiple initiation points with the increased likelihood of unfulfilled requests. A downside to this approach is loss of personal and professional contact with persons best equipped to answer important questions about data reliability and availability. Concerns about data are lost through the mediated communications currently used by the agencies. Gaining access to Medicaid data, e.g., obtaining summary measures for Medicaid data, is a lengthy process of submitting requests and waiting for a response. The process is

fraught with uncertainty. This includes the ambiguity about the validity and reliability of the data, but also the uncertainty about the timeliness of response to the data request.
/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. //2009//
/2010/ The data matching analyst hired by the MCH Assessment office has successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the data matching analyst has linked Medicaid claims of infants <1 year of age with maternal birth records.

An interagency workgroup (OHCA and OSDH) has been formed this year and is facilitated by the Senior Biostatistician in MCH. The workgroup reviews the linked data, proposes areas for further analyses of the data, shares implications for policy and program services and reviews and approves outside requests for use of the linked data. The workgroup has facilitated improved communication among analyst and policy staff of both agencies. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	82.9	69.5	72.3	70.9	72.1
Numerator	1230	1637	1826	1728	1543
Denominator	1483	2355	2527	2436	2139
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Notes - 2006
Source: Oklahoma Health Care Authority.

Narrative:
As with Medicaid data, SCHIP data are obtained indirectly by way of the OSDH Chief of the Office of Federal Funds Development. The same concerns cited for HSCI#02 above apply for HSCI#03; foremost among them are lack of direct contact with data professionals and uncertainty surrounding data quality.
/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. //2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH

Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the data matching analyst has linked Medicaid claims of infants <1 year of age with maternal birth records. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	70.8	71.5	66.4	67.2	69.4
Numerator	36219	37019	36067	37191	37518
Denominator	51157	51775	54306	55320	54047
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: Health Care Information, OSDH.

Notes - 2007
Source: Health Care Information, OSDH.

Notes - 2006
Source: Health Care Information, OSDH.

Narrative:
Data for HSCI #04 are obtained directly from the raw birth certificate files. MCH has established a working relationship with the OSDH Center for Health Statistics that permits access to raw vital statistics data. This access allows MCH to gain a richer understanding of the birth data. Specific to this measure, by having direct access to data, MCH analysts can explore issues surrounding prenatal care in depth, rather, than relying on summary measures produced by analysts external to MCH.
/2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. The linked data set will allow MCH staff to monitor initiation and frequency of prenatal care visits among women covered by the State Medicaid program. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	77.4	84.3	85.7	86.8	86.1
Numerator	385620	403023	421001	439252	448225
Denominator	498031	478007	491517	506252	520410
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Notes - 2006
Source: Oklahoma Health Care Authority.

Narrative:
Requests for Medicaid data are sent through the OSDH Chief of the Office of Federal Funds Development, who serves as the liaison for data sharing between the OSDH and the OHCA, the State's Medicaid agency. This arrangement for communication complicates a greater understanding of Medicaid data. Gaining information via a third party blocks personal and professional contact with persons best equipped to answer important questions about data reliability and availability. Concerns about data are lost through the mediated communications currently used by the State agencies. Receiving Medicaid data is a lengthy process of submitting requests and waiting for a response. The process is fraught with uncertainty. This includes the ambiguity about the validity and reliability of the data, but also the uncertainty about the timeliness of response to the data request.
/2009/ The OHCA is implementing a program called the NB1. This new service assures infants immediate enrollment into Medicaid upon birth to Medicaid-eligible mothers at delivery. Implementation is occurring on a hospital-by-hospital basis. //2009//
/2010/ Future plans are for the data matching analyst and MCH biostatisticians to explore this measure with direction from the interagency workgroup established this year. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	40.4	47.3	51.0	53.6	54.3
Numerator	36862	45222	51019	55408	57581
Denominator	91164	95686	100011	103319	106022
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Notes - 2006
Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Narrative:
Similar to Medicaid and SCHIP data, requests for EPSDT data are sent through the OSDH Chief of the Office of Federal Funds Development. Communication through third party contact is blunted, leading to inhibited understanding of the intricacies of EPSDT data. Concerns about data are lost through the mediated communications. Retrieving data from the OHCA is a drawn-out process of submitting requests, followed by long periods of no contact while waiting for a response. Data are obtained for the grant, but no real insight is gained about its quality and meaning.
/2009/ The addition of MCH Assessment staff to link and analyze matched Medicaid-vital records-PRAMS data will provide a new avenue to more fully analyze dental services provided by Medicaid. //2009//
/2010/ Future plans are for the data matching analyst and MCH biostatisticians to explore this measure with direction from the interagency workgroup established this year. This is also a priority area for the OHCA/OSDH Child Health Advisory Task Force. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	70.2	69.0	68.2	69.1	69.9
Numerator	7217	7772	8251	8843	9711
Denominator	10282	11258	12102	12805	13883
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2008 is an estimate based on the known number of SSI recipients under 18 years of age.

Notes - 2007
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2007 is an estimate based on the known number of SSI recipients under 18 years of age.

Notes - 2006
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2006 have not been published to date; therefore, a projection, which reflects a 7.5% increase from previous year's reporting, has been used.

Narrative:
Monitoring data for HSCI #08 come from CSHCN. Data are requested through routine contact with CSHCN Program staff. The State Data Contact does not access raw data; rather, aggregate data are provided so that it can be included in the Title V Block Grant Annual Report. Questions regarding the source of this information should be directed to the CSHCN Program and the Oklahoma Department of Human Services.
/2009/ No change //2009//
/2010/ No change //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	other	8	6.2	7.3

Notes - 2010
Source: 2007 Pregnancy Risk Assessment Monitoring System.

Narrative:
Monitoring data for this measure are extracted from PRAMS population-based surveillance. The PRAMS surveillance system is a joint project of the CDC and MCH. In Oklahoma, the MCH Assessment staff carries out PRAMS surveillance. As a result, PRAMS survey data can be accessed on a routine basis. However, there are often considerable delays in obtaining timely data sets for weighted analyses. This is due to the manner in which weighted data sets are generated for State use. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common. For example, surveillance data for the year ending December 2006 may not be available for analysis until mid-year 2008.
/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. In addition, an analyst was added to the MCH Assessment staff, enhancing the capacity for more comprehensive analyses. Prenatal care is a priority for analyses of the linked Medicaid-vital records-PRAMS data.//2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the data matching analyst has linked Medicaid claims of infants <1 year of age with maternal birth records. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	7.6	7.6	7.6

Notes - 2010
Source: OSDH death records. 2007 linked Medicaid/death records not available yet.

Narrative:
Infant death data by Medicaid participation are unavailable. The Oklahoma death certificate does not contain any information about Medicaid status. To tabulate infant death rates by Medicaid participation, an electronic link must be established between the death certificate file and Medicaid program data. At present, this link has not been created. The Oklahoma State Systems Development Initiative (SSDI) Project has planned to develop this link in order to enhance data capacity, but to date this information is not available.
/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. In addition, an analyst was added to the MCH Assessment staff, enhancing the capacity for more comprehensive analyses. Infant mortality is a priority set by the Commissioner of Health and MCH and is a key component of the analyses of linked Medicaid-vital records-PRAMS data.//2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the data matching analyst has linked Medicaid claims of infants <1 year of age with vital records, which will allow MCH staff to monitor infant mortality rates in the state Medicaid population. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	74	93.2	84.1

Notes - 2010
Source: OSDH death records.

Narrative:

Tracking data for this health indicator come from the PRAMS surveillance project. The PRAMS is a joint project of the CDC and MCH. As a result, PRAMS data are readily available to MCH analysts. However, there can be delays in receiving weighted analysis data sets. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common. For example, surveillance data for the year ending December 2006 may not be available for analysis until mid-year 2008.
/2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. The linked data set will allow MCH staff to monitor initiation and frequency of prenatal care visits among women covered by the state Medicaid program. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	other	72.3	83	76.6

Notes - 2010
Source: Pregnancy Risk Assessment Monitoring System 2007.

Narrative:
The Oklahoma PRAMS surveillance project provides data for tracking this health indicator. The PRAMS is a collaborative project of the CDC and MCH. MCH analysts can easily access PRAMS data. Delays in receiving a weighted analysis data set for the most recent data collection year do occur. Once a surveillance year is closed, data are sent to the CDC for cleaning and weighting. Return of a final analysis data set is determined by the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common.
/2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. The linked data set will allow MCH staff to monitor initiation and frequency of prenatal care visits among women covered by the state Medicaid program. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	185

Notes - 2010
Source: Oklahoma Health Care Authority.

Notes - 2010
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06A, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations.
/2009/ No change //2009//
/2010/ No change //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2008	 185 185 185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2008	 185 185 185

Notes - 2010
Source: Oklahoma Health Care Authority.

Notes - 2010
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06B, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations. /2009/ No change //2009//
/2010/ No change //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	185

Notes - 2010
Source: Oklahoma Health Care Authority.

Notes - 2010
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06C, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations. /2009/ The OHCA has expanded Insure Oklahoma in 2008, enabling workers and their spouses employed in businesses with up to 50 employees to be eligible for Medicaid-supported, private insurance covered through the employer. This insurance expands eligibility up to 200% of federal poverty level (FPL) for those enrolled in the new program. //2009//
/2010/ Insure Oklahoma was expanded this year to include businesses with up to 99 employees. The FPL limit remains at 200%. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Access to databases not under the direct authority of MCH remains largely unchanged. An exception is the annual data linkage of birth and infant death records. MCH, via work performed under the SSDI Project, has access to linked birth/infant death files. Plans are to maintain this linkage as routine for the MCH programs. Despite some progress on data availability, electronic linkages to other external data for Medicaid or WIC continue to be unfulfilled. MCH has limited access to registry data from hospital discharge and birth defects by means of agency partnerships established over time. The PRAMS data are collected and maintained within MCH Assessment, providing direct access to survey data and linkages to birth records. The Oklahoma SSDI Project is still active and continues to pursue access to these data. The SSDI Project is working with the OSDH Chief of the Office of Federal Funds Development, who collaborates with representatives from the OHCA to ensure data sharing between agencies. The SSDI Project anticipates and will persist in gaining access to Medicaid data. Projected timelines for access to Medicaid, WIC and newborn screening data have been incorporated into the current SSDI Project that began 1 December 2006. In addition, the inappropriate application of HIPAA rules and the nation's heightened concerns regarding terrorism over the past four years have contributed to policies intended to protect personal information. There appears to be limited understanding about what data are truly protected and what are already available through business transactions that have no protection.
/2009/ MCH has been able to fill vacant positions, providing an enhanced capacity to analyze multiple data systems. This includes a position jointly funded by OSDH and OHCA to link and analyze Medicaid data to OSDH datasets and a State Systems Development Initiative (SSDI) manager dedicated to enhancing analysis capacity for MCH. //2009//
/2010/ During state fiscal year 2009 the data matching analyst hired by the MCH Assessment office successfully linked 2005 and 2006 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the data matching analyst has linked Medicaid claims of infants <1 year of age with maternal birth records. MCH staff have utilized the linked records to compare the maternal health, demographic

characteristics, and pregnancy outcomes of women who delivered on Medicaid with women who were covered by private insurance. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
The Youth Risk Behavior Survey (YRBS) is conducted within the MCH program area. As a result, MCH analysts have direct access to data collected by the YRBS surveillance activities. The concern with HSCI #09B is ensuring that response rates with YRBS reach a level that produces a sample size sufficient for data weighting and estimation. It is intensive work to persuade schools to participate in the statewide YRBS. Experience indicates that school participation in YRBS will be a continuing challenge. Schools have a high volume of extracurricular activities that moderate their willingness to participate in surveys like YRBS. The statewide survey is conducted once every two years in accordance to the Centers for Disease Control biennial survey.
/2009/ See State Performance Measure #3 for the status of activities and collaboration. //2009//
/2010/ MCH completed the 2009 statewide random YRBS administration this spring. It is anticipated that Oklahoma will have weighted data. If this occurs, weighted data will be available for 2003, 2005, 2007 and 2009 for trend analysis. See SPM #3. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA), enacted in 1993, requires federal agencies to establish standards measuring their performance and effectiveness. Performance measures are used to monitor the effect that Title V services have on important health outcomes and processes. These measures in effect are markers of progress in improving health and reducing related risks of our target populations. While many external forces beyond the control of the Title V programs can affect these measures, they still provide direction for Title V services and assure that the focus remains on health improvement. Figure 3, Title V Block Grant Performance Measurement System, presents a schematic approach that begins with the needs assessment and identification of priorities and culminates in performance measures leading to improved outcomes for the Title V population.

Every five years, a comprehensive needs assessment is accomplished with state priorities identified. Based on these priorities, state performance measures are developed and resources allocated to impact the priorities. During interim years, needs assessment activities continue to monitor changes and identify gaps that may impact priorities and performance measures. In addition, MCH and CSHCN evaluate the resources assigned to address each priority. Based on the continuing needs assessment process and the annual evaluation of resources and their impact, state priorities may be redefined, performance measures changed and resources realigned resulting in changes in specific program activities within the four levels of the MCH "pyramid" (direct health care, enabling, population-based and infrastructure building services).

MCH uses the national and state performance measures in the agency performance and budget report submitted each fall to the state Legislature by the Oklahoma State Department of Health (OSDH). These measures are part of the OSDH strategic plan for improving the health of Oklahomans.

The national outcome measures and national and state performance measures are also shared by MCH and CSHCN with internal and external partners so they are aware of Title V priorities and the focus of resources. This assists with planning of collaborative activities and more effective use of limited resources in addressing common priorities.
/2007/ MCH and CSHCN use the monthly MCH/CSHCN Collaboration Meeting to accomplish review of national and state performance measures and related activities. As needed change to a performance measure or activity is identified and agreed upon, steps to accomplish the change, identification of the responsible individual(s) to assure the steps are taken and timelines for progress are established to facilitate accomplishing the identified change. Participation of families and other key partners is critical in assuring input is received to guide decision-making. //2007//
/2009/ The OSDH is implementing an electronic performance management system, Step UP ("Strategies toward excellent performance---Unlimited Potential"). Staff from MCH participated in development of the system and MCH is currently participating in the pilot phase. MCH national and state performance measures have been input into the system and will be updated annually as is done with the federal Title V MCH Block Grant. The goal of the system is to "optimize human potential within the OSDH by increasing alignment of strategic initiatives toward the defined organizational goals and objectives and providing accountability to stakeholders."

MCH and CSHCN have moved to meeting every other month. Meetings continue to be focused on collaborative planning related to state priorities, outcome measures and performance measures. //2009//

/2010/ With the comprehensive needs assessment in process for the 2011 Title V MCH Block Grant application, MCH and CSHCN have moved back to meeting monthly to assure continuous coordination of activities. The Executive Director of the Oklahoma Family

Network has become a routine participant in these meetings to facilitate integration of families into planned activities.

The annual update into the OSDH Step Up system will be completed by August 1. The OSDH also created a state health report card this year on specific health indicators to include several related to the MCH populations. MCH was involved in development of the report card, which includes priorities such as infant mortality, unintended pregnancy, adolescent pregnancy, etc. The report card is to be updated every three years. //2010//

B. State Priorities

The selection of Oklahoma priorities began with a new needs assessment process that assured input from a broad group of individuals from across the state rather than just Title V staff. Three teams were organized to assist the Title V Program in identifying needs from the perspectives of service providers, consumers, advocates and other state and community-based agencies. The three teams represented the three MCH population groups: women and infants, children and adolescents and children with special health care needs. Individuals were identified to represent the broad scope of Title V services and activities and invited to participate in a planning meeting followed by subsequent separate meetings to identify needs for their respective populations. MCH and CSHCN program staff strictly limited their participation to being group facilitators to avoid unnecessary influence from an internal perception of issues and problems.

The initial planning meeting was held for all participants to provide them with a background of Title V, an explanation of the legislation mandating performance-based planning and expectations of each group to provide useful feedback for setting state priorities. The three groups worked independently June through October 2004 and were given wide latitude in determining their recommendations. They were offered access to any available data to support their identification of needs. Upon completion of their work, a list of priorities was submitted by each group that identified the highest needs of their respective population groups of women and infants, children and adolescents and children with special health care needs.

MCH and CSHCN leadership reviewed these recommended priorities to assess and compare them to the mission of Title V and the scope of the MCH and CSHCN programs. A preliminary set of priorities was then selected that best fit the highest priorities of each of the three groups; consideration was given to overlap, mandated services and historical priorities.

An analysis of data was accomplished to determine what needs could be quantified. Data were analyzed from the following sources: population-based surveillance data from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Centers for Disease Control and Prevention (CDC) weighted Oklahoma Youth Risk Behavior Survey (YRBS), the Oklahoma First Grade Health Survey, and the Oklahoma Fifth Grade Health Survey; Oklahoma vital records; 2000 U.S. Census and Census population estimates; the State and Local Area Integrated Telephone Survey (SLAITS); needs assessments of other Oklahoma MCH programs; private, non-profit health-based surveys or studies; agency program data from the OSDH and the Oklahoma Health Care Authority (Medicaid data); and, other federal and state surveys. These data were reviewed and analyzed to assess need and to compare with the qualitative assessments provided initially by the three groups.

A final examination of the initial priorities was then made by MCH and CSHCN to assure that the identified issues remained consistent with their own experiences as well as the priorities of the respective agencies. The priorities were modified slightly, based upon a careful review of the resources available and the relationship of Title V to other services that will partner with the MCH and CSHCN efforts (note that no one priority is ranked higher than another):

1) Reduce the prevalence of obesity among the MCH populations

2) Reduce substance abuse behaviors in the MCH populations
3) Improve access to dental health services by pregnant women and children
4) Increase access to prenatal care
5) Improve the system of respite care for CSHCN families
6) Improve transition services for adolescents with special health care needs
7) Reduce unwanted, unplanned pregnancies
8) Increase the proportion of fully immunized children entering school
9) Increase the proportion of mothers who breastfeed their infants
10) Improve data access and file linkages of public health databases

Next, MCH and CSHCN analyzed existing national performance measures and current state performance measures to determine their usefulness in addressing the new priorities. It was noted that national performance measures addressed several of the state priorities. State performance measures no longer pertinent to the priorities were discontinued, and new measures were created to assist the state in monitoring its progress toward impacting the priorities. Four previous state performance measures were retained with three new state performance measures* developed for 2006:

1) The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.
2) The percent of mothers who smoke during the third trimester of pregnancy.
3) The percent of adolescents grades 9-12 smoking tobacco products.
4) The number of families with a child with special health care needs receiving respite care provided through the CSHCN Program.
5)* The percent of first grade students at risk for overweight (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution).
6)* The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.
7)* Percent of children with special health care needs that receive timely and appropriate transition services.

/2007/ Two state performance measures have been discontinued and new measures identified as a result of comparison of state performance measures with new and revised 2006 national performance measures. State performance measure #2 "The percent of mothers who smoke during the third trimester of pregnancy" was found to be duplicative of the new 2006 national performance measure #15 "Percentage of women who smoke in the last three months of pregnancy" recently identified in the updated Maternal and Child Health Services Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report released in May 2006. State performance measure #7 "Percent of children with special health care needs that receive timely and appropriate transition services" was found to be very similar to the revised national performance measure #6 "The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence."

MCH and CSHCN reviewed written documentation of input received from stakeholder groups during the five-year needs assessment process completed in 2005 as well as identified state priorities. The following new state performance measures have been established using this information: state performance measure #7 "The percent of Medicaid eligible children with special health care needs who report receiving routine dental care" and state performance measure #8 "The percent of adolescents grades 9-12 not using alcohol during the past 30 days." //2007// /2008/ There are no new state performance measures identified by MCH and CSHCN. //2008// /2009/ In April 2007, MCH was requested by the Commissioner of Health to provide leadership in facilitating an OSDH intra-agency strategic planning process to strengthen collaboration among all OSDH programs with common activities targeted toward improving infant outcomes in a overall agency focused effort to reduce Oklahoma's unchanging infant mortality rate (though the overall focus is reduction of infant mortality, within this is the concern of the ongoing disparity with

the African American population). In May 2007, the first meeting of the intra-agency workgroup occurred with subsequent meetings continuing on a monthly basis to date. Efforts of the workgroup have focused on review of data, current crosscutting program activities and gaps needing to be addressed to include activities targeting specific racial and ethnic groups. Over the year, smaller workgroups to focus on identified areas of priority have been formed: breastfeeding; childhood injury; data; maternal infections; preconception/interconception care and education; postpartum depression; safe sleep; and, tobacco. The leads of these small workgroups report planned activities back to the large workgroup with a strategic plan being developed for use in OSDH 2009-2010 budgetary, policy and program services decision-making. The 2009-2010 strategic plan is the first step in an expected ongoing strategic process that will look to not only strengthen internal OSDH efforts in reducing infant mortality but also strengthen linkages with OSDH state partners in statewide interagency efforts.

The infant mortality reduction strategic planning process has not resulted in changes to the identified Title V state priorities as the MCH priorities identified have a direct impact on the already identified Title V outcome of infant mortality. The process has provided an opportunity to further educate and reinforce MCH priorities (1. Reduce the prevalence of obesity among the MCH population; 2. Reduce substance abuse behaviors in the MCH populations; 3. Improve access to dental health services by pregnant women and children; 4. Increase access to prenatal care; 7. Reduce unwanted, unplanned pregnancies; 9. Increase the proportion of mothers who breastfeed their infants; and, 10. Improve data access and file linkages of public health databases) and their relationship to impacting infant mortality with other OSDH programs. Work from the small workgroups is being incorporated in the planned activities of currently identified national and state performance measures that focus on these priorities.

State performance measure #5 The percent of adolescents at risk for overweight (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution) is being discontinued for 2009 with a new state performance measure #9 The percent of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution) being added. This change is being made as MCH found on review of state performance measure #5 data that previous reporting included only those adolescents at risk for overweight and not those who were overweight. In addition, CDC now uses the terms overweight and obese; the term "at risk" is no longer used. //2009//

/2010/ MCH has historically assured that activities to support prevention of Sudden Infant Death Syndrome occur. As described last year, see F. Other Program Activities, MCH planned to conduct a survey of nurses working in hospitals and birthing facilities to gain information regarding nursing staff knowledge of their facilities written policies on infant safe sleep, staff training provided on infant safe sleep to include placing infants on their backs to sleep and education provided to parents prior to discharge. MCH conducted the survey with nurses working labor and delivery, postpartum, nursery and/or neonatal intensive care units in hospitals and birthing facilities providing over 15 deliveries a year. The results of the survey indicate the need to provide hospitals with sample policy and nurses with education on infant safe sleep so that they are better informed in providing information to and modeling appropriate infant safe sleep practices for families. There were 399 nurses who responded from 46 hospitals. Survey data indicate only 51.1% of respondents said their hospital had a written policy regarding infant safe sleep. Almost 22% of respondents answered that infant safe sleep education is given "as needed" and not on a regular basis. Only 24% indicated receiving education annually.

In addition, for 2007, the most current Pregnancy Risk Assessment Monitoring System (PRAMS) data available, 60.9% of all infants in Oklahoma were placed on their backs to sleep at two to six months. The Healthy People 2010 goal is for 70% of healthy, full term infants to be placed on their backs for sleep on all occasions. In Oklahoma, 60.3% of full term infants were placed to sleep on their backs for most sleep occasions.

Given this information, MCH and CSHCN made the decision to add a new state performance measure this year, state performance measure #11 "The percentage of full-term infants who are put to sleep on their backs." //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	31	54	50	67	58
Denominator	31	54	50	67	58
Data Source					Screening and Special Services, OSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

Notes - 2007
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

Notes - 2006
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

a. Last Year's Accomplishments
All newborns born in Oklahoma were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) and other amino acid disorders, congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, cystic fibrosis (CF), congenital adrenal hyperplasia (CAH), medium chain acyl-CoA dehydrogenase deficiency (MCAD) and other fatty acid disorders, and organic acid disorders. The number of disorders identified in calendar year (CY) 2008 included: PKU (1) and Hyperphe (3); congenital hypothyroidism (20); classic galactosemia (0); sickle cell disease (10); hemoglobin disease (3); CF (10); CAH (2); Fatty acid disorders -MCAD (4);SCAD (4); Amino acid disorders - Citrulline (1) hemoglobin C trait (141); and sickle cell trait (468). One hundred percent of newborns received short-term follow-up (STFU) services for diagnosis and 100% of affected newborns were referred

to long-term follow-up (LTFU) for care coordination services.

For CY 2008, 100% of the sickle cell traits and hemoglobin C traits were referred for counseling and 46 (out of 607) families received counseling from a board certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (114 of the 114 received counseling). One newborn identified with a disorder other than CF received genetic counseling from a board certified genetic counselor, a board certified geneticist counseled the other cases.

The Oklahoma State Department of Health (OSDH) Board of Health mandated through rules passed on February 7, 2008 an expansion to the uniform panel of screenings. Reporting on the first group of new disorders in the expanded panel began on May 27, 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened all newborns in Oklahoma for mandated conditions			X	
2. Provided short-term follow-up for all newborns identified at risk for a disorder or trait		X		
3. Provided long-term follow-up for all diagnosed newborns except cystic fibrosis (CF); linked all infants with CF to CF Center		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Expansion to adopt the uniform panel recommended by the American College of Medical Genetics (ACMG) is completed for the amino acid disorders, fatty acid disorders and the organic acid disorders. Current Oklahoma screening includes 53 of the 54 core disorders. Current activities include acquiring follow-up staff, developing follow-up protocols and lab validation studies. The only disorder on the ACMG panel that is pending is Biotinidase.

Long-term follow-up care coordination services are being provided to children and youth with special health care needs and include an Adult Transition Program for adolescents with sickle cell disease and a PKU Formula/Food Program.

State appropriated line item funding for the Sickle Cell Association was eliminated this year due to the state's budgetary constraints. This hinders advocacy activities, such as school individual education plan (IEP) assistance and transition planning, for individuals who have been identified with sickle cell disease, sickle cell trait as well as advocacy and support for families.

c. Plan for the Coming Year

All newborns born in Oklahoma will continue to be screened through the NSP for the disorders of PKU, congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, CF, CAH and MCAD. It is anticipated that Biotinidase will be added to the current panel by early 2010 pending laboratory space and machinery. Additional equipment will need to be purchased to screen for Biotinidase deficiency. The OSDH Public Health Laboratory has included this in their

state fiscal year (SFY) 2010 budget.

The NSP will maintain comprehensive STFU services to assure all infants with out-of-range screen results are followed until resolution (e.g., diagnosed as normal, affected or lost to follow-up). Affected newborns will be followed until documentation of treatment date (if applicable), referral to pediatric sub-specialist, genetic counseling date and enrollment into available LTFU services. In collaboration with the University of Oklahoma Health Sciences Center (OUHSC), the NSP will continue to provide LTFU services to all affected newborns except for those diagnosed with CF. Infants diagnosed with CF will continue to be referred to the CF Center in Tulsa or Oklahoma City (follow-up for CF ceases once NSP confirms that the infant has been seen by a pediatric pulmonologist). Currently three fulltime LTFU care coordinators (Metabolic, Endocrine and Sickle Cell Disease) and one metabolic dietitian are supported through contracts with the OUHSC. STFU and LTFU services are provided in collaboration with the medical home. Genetic counseling for CF and hemoglobins is provided in Oklahoma City and Tulsa through contractual agreements.

The NSP will continue to provide education and low-phenylalanine formula to adults and low-protein food to children with PKU.

An evaluation of the state genetics plan continues in collaboration with the Evaluation Committee of the Oklahoma Genetics Advisory Council (OGAC). Implemented activities of the plan will continue including educational outreach. The metabolic workgroup will continue to meet to facilitate implementation of expansion of the ACMG uniform panel. The OGAC will continue to meet three times a year and its nine committees will meet as needed. The Newborn Screening and Pediatrics Committee of OGAC will continue to address newborn screening follow-up.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	53.8	54.9	56	57.4	58.8
Annual Indicator	50.4	50.4	50.4	56.9	56.9
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60.9	61.5	62.7	63.9

Notes - 2008
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The 2005-2006 State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) data showed 56.9% of families (with a member who was a child under 18 years of age with special health care needs) were partners in decision making at all levels and were satisfied with the services they received. This is an increase from the 2001 survey that found 50.4% of families were satisfied.

CSHCN contracted with the University of Oklahoma, Child Study Center (OU CSC), Sooner SUCCESS Project to provide families, educators, social and health professionals and others a structure to enhance capacity and effectiveness in building an integrated, comprehensive system of health, mental health, social and educational services supporting children and youth with special health care needs and their families in their own communities. The project partnered with family members at all levels of the project in the counties served: Blaine, Canadian, Garfield, Logan, Kingfisher, Major, Creek, Rogers and Tulsa. The State Interagency Coordinating Council had four family members to represent larger networks of families (Oklahoma Family Network, University Center for Excellence in Developmental Disabilities family faculty, Family Support 360 Project) throughout the state. A core family member participated on each of the nine Sooner SUCCESS county coalitions. These family members were supported with reimbursement for their participation. The family perspective was strongly represented throughout the project. Sooner SUCCESS employed family members in key roles at all levels of the project. The State Coordinator, Administrative Secretary and three of the county coordinators have children or siblings with special health care needs.

The Children's Oral Health Coalition (COHC) developed "A Guide for Family Members/Caregivers and Dental Providers". This handbook was developed to facilitate communication between families and professionals. Detailed descriptions were included on common issues with children with special needs and strategies to create a less stressful appointment for both the child and the professional. The handbook gave helpful information to caregivers on how best to communicate their child's needs to dental professionals. In addition, a pamphlet version was developed and placed on the website of the Oklahoma Association of Community Action Agencies (www.okacaa.org).

CSHCN maintained contracts with several organizations that have paid family members on their staffs: Oklahoma Areawide Services and Information System (OASIS), Oklahoma Infant Transition Program, Tulsa Neonatal Follow-up Clinic and the Autism and Sickle Cell clinics at the University of Oklahoma Health Sciences Center (OUHSC).

On April 26, the Oklahoma Family Network (OFN), with support of MCH and CSHCN and technical assistance and support from National Family Voices, presented the first "Joining Forces Conference" with 112 individuals in attendance. Family members and representatives from state agencies shared information and discussed ways to improve services throughout Oklahoma.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported Sooner SUCCESS regional care coordination activities		X		
2. Participated in the development of a handbook about CSHCN and dental health for caregivers				X
3. Supported parents as paid staff of organizations providing CSHCN services		X		
4. Collaborated with the Oklahoma Family Network and MCH to provide first annual conference focused on family/professional partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In eastern Oklahoma, the Tulsa Neonatal Follow-up Clinic provides assistance to infants coming out of the neonatal intensive care unit (NICU). Staff members coordinate with family and NICU staff to find an appropriate medical home when the child is released. Education and support are offered at the clinic or, if necessary, a referral is made to an outside agency. All clinic visits are reported to the child's medical home to facilitate continuity and quality of care.

Sooner SUCCESS continues to work on systems improvement in three broad areas: increased service capacity; increased access to services; and, community-based needs assessment.

The OFN is partnering with OUHSC occupational and physical therapy students to develop a health care information sheet for children and youth with special health care needs. The information sheet is designed to help parents/caregivers record information as they navigate their child through the health care and education systems so they can make well-informed decisions.

The OFN hosted the 2nd annual conference to support partnerships between families and professionals. "Joining Forces: Supporting Family/Professional Partnerships" was held in Oklahoma City on April 25, 2009. One hundred nineteen (119) individuals attended with half indicating they were family members. Seven state agencies and 17 family organizations were represented. Also in attendance was a staff of Senator Tom Coburn.

c. Plan for the Coming Year

CSHCN will continue to support Sooner SUCCESS as well as continue funding for parents as paid staff members at the Autism and Sickle Cell clinics at the OUHSC, OASIS, Oklahoma Infant Transition Program and Tulsa Neonatal Follow-up Clinic.

The OFN plans to continue partnering with OUHSC occupational and physical therapy students to develop health care information sheets for families of children and youth with special health care needs. The information sheets will assist families to be better prepared to partner in decision-making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	56.7	57.8	59.3	60.5	60.5
Annual Indicator	53.3	53.3	53.3	49.7	49.7
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50.2	50.7	51.2	51.7	52.2

Notes - 2008
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The 2005-2006 State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) data found that 49.7% of children 18 or younger with special health care needs received coordinated, ongoing, comprehensive care within a medical home in Oklahoma. This has declined since 2001 when 53.3% of families received care in a medical home.

In the fall of 2007, the Sooner SUCCESS State Coordinator and Medical Home Coordinator provided training to 24 SoonerStart resource coordinators on how to collaborate with primary care physicians who provide services through a medical home. SoonerStart, Oklahoma's birth to 3 early intervention program, is a multi-agency program designed to assist infants and toddlers diagnosed with disabilities and developmental delays.

The Family Support 360 Center Medical Home Project, designed to serve families with low income whose children have developmental disabilities, provided training to medical practitioners. This training promoted best practices and partnerships in meeting the needs of families whose

children have developmental disabilities. The Family Support 360 Center added approximately fifty new families to its caseload.

The Fostering Hope Clinic, a multi-agency collaboration that provided medical homes for children in Oklahoma Department of Human Services' (OKDHS) custody, completed its third year. The clinic operated two days each week. The clinic followed the Standards for Health Care Services for Children in Out-of-Home Care developed by the American Academy of Pediatrics (AAP) and the Child Welfare League of America. A doctoral prepared (Ph.D.) psychologist screened every child seen at the clinic and assessed as needed.

The Medical Home Program for Medicaid eligible children and youth served at the University of Oklahoma Child Study Center (OU CSC) provided an opportunity to address the Maternal and Child Health Bureau's medical home component of an integrated system. The Medical Home Program for Medicaid eligible children and youth worked on developing recommendations for the Oklahoma Health Care Authority (OHCA), Oklahoma's Medicaid agency, to establish specific criteria for a practice to be considered a medical home. The criteria serve as the basis of a quality improvement process. Criteria are to be integrated into practices and incentives provided for primary care practices to meet the criteria. Through this effort, seven primary care providers received training and technical assistance on varying components of the medical home. Most of the activities with these providers were in the area of screening and referral.

Collaboration with OU CSC, the Utah Collaborative Medical Home Project and the Oklahoma Joint Oklahoma Integrated Network (JOIN)/211 continued as Oklahoma medical home portal pages were developed. The Utah Med Home Portal (located at http://www.medhomeportal.org) was developed to give primary care providers as well as families the tools they need to give the best care and treatment to children with chronic conditions. It provides information on what a medical home is, useful information put together by families to help other families, listings of school and education resources and personnel, modules on conditions and their diagnoses, information about transition issues and extensive lists of resources. Oklahoma 211 began changes to their system to make the link between the Utah Med Portal site and community resources listed by JOIN/211. OU CSC staff looked for medical professionals to be contributors and Utah staff prepared pages with sample data sent to them.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported Sooner Success in training resource coordinators on how to collaborate with CSHCN medical homes				X
2. Supported the Family Support 360 Project, Fostering Hope Clinic and University of Oklahoma (OU) Child Study Center to provide services using the medical home model		X		
3. Collaborated with OU Child Study Center, Utah Collaborative Medical Home Project and Joint Oklahoma Information Network (JOIN)/211 to develop Oklahoma medical home portal pages				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Ten primary care practices are receiving support from the OU CSC Medical Home Program in Canadian and Garfield counties to implement medical home concepts into their practices.

Planning continues on the Oklahoma Med Home Portal Project. The Utah Med Home Portal staff worked on templates for the Oklahoma pages. OU CSC continues to seek professionals and family representatives throughout Oklahoma to provide materials to include on the Oklahoma web pages. As regional 211s complete upgrades to their systems, each will work with Utah Med Home Portal staff to link their systems.

The Fostering Hope Clinic, in its fourth year in Oklahoma City and second year in Tulsa, continues to provide a medical home for children in child welfare custody.

The Tulsa Neonatal Follow-up Clinic provides assistance to children coming out of the neonatal intensive care unit (NICU). All visits to the clinic are reported to the child's medical home to facilitate continuity and quality of care.

On January 1, 2009, the OHCA initiated a medical home model for the SoonerCare (Medicaid) Program using the AAP's medical home principles. Since this model will allow access to providers other than the child's primary care provider, children with special health care needs will be able to access specialty care and the OHCA will be able to reimburse providers without the previous barriers encountered under a managed care model.

c. Plan for the Coming Year

Oklahoma became the first state in which the governor issued an official proclamation in support of the American Academy of Pediatric Dentists (AAPD) and Head Start Dental Home Initiative and congratulated them for their efforts. The partnership between Head Start (HS) and Early Head Start (EHS) and AAPD to help children find dental homes will continue to grow. The two-pronged HS Dental Home Initiative will organize networks of dental professionals who will agree to be a dental home. It will also train HS and EHS staff in how best to communicate to parents the importance of effective oral health practices and having a dental home for their children.

To help families become stronger advocates for their children, the Oklahoma Family Network (OFN) plans to partner with two hospitals in Oklahoma to provide trained OFN staff to visit and provide information and emotional support to families with children admitted to the neonatal and pediatric intensive care, pediatric and oncology units of the hospitals.

The Fostering Hope and Tulsa Neonatal Follow-Up clinics will continue to provide services that emphasize the importance of a medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	59.5	61	62.5	64.1	62.9
Annual Indicator	56.4	56.4	56.4	61.6	61.6
Numerator					
Denominator					
Data Source					National Survey of CSHCN

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.2	65.5	66.8	68.1	69.4

Notes - 2008
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) data for 2005-2006 demonstrates that 61.6% of children 18 or younger with special health care needs had adequate levels of insurance coverage to provide for required health services. This is an improvement from the 2001 survey when 56.4% reported adequate levels of insurance coverage.

According to statistics from the OHCA, there was a 14.7% increase in the number of children and youth with special health care needs receiving services through the Medicaid Program. Children continued to be approved for and receive services through the Tax Equity and Fiscal Responsibility Act (TEFRA) Program that provided Medicaid services to children who were ineligible for SSI (Supplemental Security Income) but met nursing home or hospital level care and were able to reside at home. Enrollment in the TEFRA Program grew to 229, up from 164 the previous year.

The Oklahoma Health Care Authority (OHCA) and CSHCN continued to work toward the goal of having Medicaid cover metabolic formulas. Discussions centered on the number of individuals who would be impacted and the specific conditions that would be covered. The OHCA believed it should be possible to cover formula for children with metabolic disorders. Their next step was to determine if providing formula for non-metabolic disorders met the definition of medical necessity so it could be covered under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

All families receiving support and services through the Sooner SUCCESS Project received assistance with identifying the appropriate mechanism for paying for the services they needed. County coordinators responded to 752 families. The Oklahoma Areawide Services and Information System (OASIS) Family Outreach Coordinator put together three regional family support focused "On the Road" conferences providing information and resources to 220 family participants. Agency representatives provided information on services such as SoonerStart,

developmental disability services, the SSI Disabled Child Program as well as the Medicaid and EPSDT programs.

CSHCN continued to participate as part of the state level Child Health Advisory Task Force. This task force, chaired by the Chief of MCH and OHCA Child Health Director, provided a forum for family and professional input into policy and services evaluation, revision and development.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked to change Medicaid policy to include metabolic formulas				X
2. Supported Sooner SUCCESS and the Oklahoma Areawide Services and Information System (OASIS) in their efforts to link CSHCN to appropriate resources		X		
3. Participated as member of the Child Health Advisory Task Force				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHCA reports that Medicaid enrollment among children with special health care needs increased by 3.6% in 2008. CSHCN continues to work with the OHCA to ensure services that are compensable under the EPSDT Program are covered through Medicaid. This past year MCH and CSHCN worked through several issues with the OHCA so that Medicaid will provide metabolic formulas and foods that are currently being provided with Title V funds. CSHCN sent letters to families and providers detailing the process through which these items can now be covered under Medicaid.

"On the Road" conferences, organized by the Family Perspective Committee of the OASIS, are held to help families learn what services are available through programs such as SoonerCare, SoonerStart and Title V. The conferences are held at different times of the year in different cities and towns around the state to allow as many families as possible to attend at least one event. CSHCN participates in these conferences as well as meeting with other parent and professional groups to explain the eligibility requirements of SoonerCare, TEFRA and the Disabled Child Program (funded by Title V) as well as what services are provided by these programs.

c. Plan for the Coming Year

The Family Perspective Committee is made up of parents and family members of individuals with disabilities. The common purpose of the committee is to improve the lives of children and youth in Oklahoma with disabilities throughout their lifespan by bringing issues, recommendations and action steps to the attention of the Oklahoma Commission on Children and Youth (OCCY). The committee will continue to change content of the "On the Road" conferences so that as much useful information is provided as possible to as many families as possible.

This past year the OHCA's Insure Oklahoma Program expanded eligibility to businesses with 99

or less employees. Previously only businesses with 25 or less employees could enroll in the Insure Oklahoma Program. Insure Oklahoma provides access to insurance coverage to certain populations that are not eligible for Medicaid benefits. The OHCA also increased the income eligibility standards for Insure Oklahoma from 200% of the federal poverty level to 250%. It is expected that this expansion will provide access to insurance coverage to some children in the CSHCN population who are currently without coverage.

The CSHCN Director will continue to attend the Child Health Advisory Task Force meetings. The task force will discuss and make recommendations for further data and policy analysis, service development and process changes to benefit the health of Oklahoma's children.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	69.7	71.4	73.2	75.1	91
Annual Indicator	67.6	67.6	67.6	90.3	90.3
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	93	94	95	96

Notes - 2008
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005-2006 State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) data shows the services of 90.3% of children under the age of 18 with special health care needs were organized in ways that families could easily use them. This was an improvement from the findings of the 2001 survey when 67.6% of families found services were organized for easy access.

CSHCN continued to attend events around the state, such as the family focused "On the Road" Conference in Poteau, the annual Metro disABILITY Resource Conference and the annual Governor's Conference on Disabilities, to inform families of available services through Title V. CSHCN also held training sessions to educate Oklahoma Department of Human Services (OKDHS) staff on Title V programs and how best to help families access them.

Sooner SUCCESS fulfilled 752 requests for service coordination in the nine counties in which the project operated. County coordinators helped the Northwest Center for Behavioral Health in Fairview add an additional full-time counselor and the Oklahoma Play Therapy Counseling Center, based in Enid, set up a satellite office in Fairview.

The Oklahoma Family Network (OFN) provided leadership for the "Joining Forces Conference". The goal of this annual event was to facilitate communication between families and agencies to improve services throughout Oklahoma (see NPM #2). One attendee reported to the OFN she organized a family support group soon after the conference.

A new Oklahoma Sickle Cell Council was established. The council brought together representatives of the Oklahoma branch of the Sickle Cell Disease Association of America, medical professionals working with sickle cell patients, patients (and their families) and community organizations. The council planned to meet 3 times per year. Issues addressed included access to health care for uninsured patients (with a review of special programs offered by the Oklahoma Health Care Authority) and school accommodations needed for children with sickle cell disease.

The Children's Oral Health Coalition (COHC) produced a toolkit intended to make dental visits less stressful for families and professionals. The toolkit was made available to the public on the Oklahoma Association of Community Action Agencies website (www.okcaa.org). The toolkit gives helpful hints to families and professionals on how to deal with specific concerns (such as seizures and touch-related aversions) that may come up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreached to families with CSHCN to inform them of available state benefits and programs		X		
2. Supported Sooner SUCCESS, the Oklahoma Family Network, the new Oklahoma Sickle Cell Council and the Children's Oral Health Forum to assure communities worked toward having service systems organized for ease of use by families		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Sooner SUCCESS county coordinators continue to help families access services that they were not aware of when referred to the Sooner SUCCESS Project. Many of the services are provided by public service agencies, some are provided by private organizations while others are organized innovatively around the unique needs of the individual family.

Local Sooner SUCCESS coalitions continue to identify needs through the process of helping families access services or through the needs assessment, and to develop strategies to meet some of those needs. Examples of capacity development activities include establishing access to mental health counseling services in two counties where services were not present before, establishing a sibling support group and providing multiple training events for providers and families on best practices for serving children and youth with autism spectrum disorders.

The OFN is enlisting families to provide guidance to several components of Oklahoma government to better organize provided services. The OFN recommended 15 family leaders to provide policy review for the OKDHS Developmental Disabilities Services Division (DDSD) Advisory Committee.

CSHCN regularly attends the "On the Road" Family Perspective conferences sponsored by the Oklahoma Areawide Services and Information System (OASIS). These conferences inform families of children with special health care needs and medical providers about available services and how to access them.

c. Plan for the Coming Year
The OFN's Maternal and Child Health Bureau (MCHB) funded Family-to-Family Health Information and Education Center Project will enable the OFN to offer more resources and support to help the CSHCN population receive quality health care. Goals include strengthening statewide support of the CSHCN population by identifying, mentoring and training family leaders and to develop and implement a data collection and evaluation system to assess the effectiveness of the project.

The OFN will continue collaboration with the Oklahoma Parent Training and Information Center (OPTI). The OPTI assists with school supports or school type training and will refer families to the OFN for mentorship, training and assistance. The OFN will also continue their collaborations with the University of Oklahoma Child Study Center (OU CSC), the Oklahoma State Department of Education and the University Center for Excellence. They will assist in finding knowledgeable individuals to speak to professionals, parents and students about children and youth with special health care needs. The OFN will continue to participate on the Child Health Advisory Task Force, a joint collaboration between the Oklahoma State Department of Health, the Oklahoma Health Care Authority and partnering agencies.

As a result of last year's block grant review recommendation to improve collaboration with faith-based groups, CSHCN met with the Coordinator of the Office of Faith-Based and Community Initiatives (OFBCI) at the OKDHS to discuss future collaborations. This office seeks to link government agencies with faith-based organizations to provide social services. One of the office's priorities is to inform, motivate and enlist the faith community in addressing the needs and issues facing foster care children, one of the target populations for CSHCN. Plans are to collaborate with the OFBCI to gain access to the faith-based community and obtain input for the Title V Comprehensive Needs Assessment to be submitted with the 2011 Title V Grant application.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8.2	8.2	6	6.2	45
Annual Indicator	5.8	5.8	5.8	43.7	43.7
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	47	48	49	50

Notes - 2008
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments
The 2005-2006 State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) data indicate that 43.7% of children under the age of 18 received the services necessary to make appropriate transitions to adult health care, work and independence. Comparisons cannot be made to 2001 data due to a change in the questions from the previous version of the survey.

The Oklahoma Transition Council was created so those concerned with secondary transition education could work together. Council membership includes Sooner SUCCESS, Oklahoma State Departments of Education, Human Services, Mental Health and Substance Abuse,

Rehabilitation Services, Zarrow Center for Learning Enrichment, advocacy group representation, private organizations, family members and youth. Thirty-five teams were developed to facilitate collaboration and coordination between school administrators, parents, vocational rehabilitative counselors and other professionals in school systems across the state. The Council has held three Oklahoma transition institutes (OTI) to bring the teams and council members together to learn about transition issues and coordinate regional and statewide efforts. The 2008 OTI was held September 3-5, 2008. During the 2008 OTI, team facilitators learned ways to support and build their teams as they identified existing resources and needs and made plans for their home communities. The teams were encouraged to disseminate information about the statewide transition initiative and motivate people to participate in local teams. All teams planned to get back together to report on their progress, access facilitators and each other for technical assistance and refine their strategic plans. Breakout sessions at the institute included: student-centered transition processes; family empowerment; creating school transition coordinator positions; transition and foster families; assistive technology; transition to post secondary education; and, transition issues with Native American youth.

The Oklahoma Pediatric Sickle Cell (OPSC) Program conducted a telephone survey of young adults who had already transitioned to adult health care from the program within the previous five years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated on the multi-agency Oklahoma Transition Council which hosted the third annual "Transition Institute" for training community-based teams				X
2. Supported the Oklahoma Pediatric Sickle Cell Program's survey to assess young adults already transitioned to adult care				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Analysis of the OPSC data, which addresses the effectiveness of transition services and medical/social issues being encountered by young adults after transition, is currently being completed.

The Oklahoma Transition Council is an interdisciplinary, interagency group working toward improved transition practices across multiple agencies. The council is planning its fourth annual Oklahoma Transition Institute (OTI) in September 2009. The OTI provides facilitators that support teams as they identify existing resources and needs and make plans to build their team on their return to home communities. These teams disseminate information about the statewide transition initiative and encourage individuals to participate on their local teams. All teams will get back together later in the fall through regional meetings to report on their progress, access facilitators and each other for technical assistance and refine their strategic plans.

c. Plan for the Coming Year
The Autism Network at the University of Oklahoma Health Sciences Center will continue to collaborate with Oklahoma Family Center for Autism to continue transition education for youth with autism spectrum disorders (ASD).

In partnership with Redlands Community College and Family and Youth Services, the Oklahoma Family Center for Autism will establish a residential, academic and social support at the college for students with ASD and other developmental disabilities. There will also be a summer institute for parents, students with ASD and professionals that focuses on transition education.

Senate Bill 283 was passed by the legislature this year and will create the Task Force on Youth Transitioning into Adulthood. The bill directs the task force to conduct an in-depth study of Oklahoma's disconnected youth and the issues that directly impact their ability to achieve financial independence and life skills. The CSHCN Director has been in contact with the sponsors of the bill and received assurance that CSHCN will be involved as the task force work moves forward and that youth with special health care needs will not be overlooked in this study.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	82	83.6	74.2	76.4	80.8
Annual Indicator	72.0	75.7	80.4	80.1	80.1
Numerator	34215	37087	40268	41564	41564
Denominator	47521	48992	50085	51890	51890
Data Source					National Immunization Survey & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82.1	83.4	84.7	86	87.3

Notes - 2008
Source of data: CY2008 data not yet available, hence CY2007 data is used as a placeholder. Numerator is estimate from National Immunization Survey, Q1/2007-Q4/2007, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Population data in denominator were obtained from the U.S. Bureau of the Census.

Denominator is 2008 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

Notes - 2007
Source of data: Numerator is estimate from National Immunization Survey, Q1/2007-Q4/2007, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Population data in denominator were obtained from the U.S. Bureau of the Census.

Annual Performance Objectives for 2008-2012 have been revised to reflect expected increase in % of 19-35 month olds receiving vaccinations. OSDH will be launching Operation Buzzer-Beater to ensure vaccinations of 24 month-olds who have not received sufficient immunization shots.

Notes - 2006
Source of data: Numerator is estimate from National Immunization Survey, Q1/2006-Q4/2006, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Population data in denominator were obtained from the U.S. Bureau of the Census.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from NIS survey.

a. Last Year's Accomplishments
National Immunization Survey (NIS) results for year 2007, the latest data available, showed a coverage rate of 80.1% for children less than two years of age who had received these immunizations. With these results, Oklahoma maintained its national rank of 25 for the second consecutive year. In 2005, Oklahoma ranked 44th with a coverage rate of 76%.

The Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child that presented at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations were provided to an insured child, county staff worked with the parent/guardian to link the child with his/her primary health care provider for future immunizations. Additionally, county health departments were able to recoup year-round cost reimbursement for services provided to Medicaid eligible children for the fourth consecutive year and the OSDH Immunization Service continued to receive Medicaid administrative funds to support the Oklahoma State Immunization Information System (OSIIS).

MCH continued collaboration with the OSDH Immunization Service on The OK by One Project. This project, modeled after a similar project in New Mexico, was implemented in 2004 as a strategy to improve vaccine protection levels and particularly that of the 4th DTaP, a common problem found in low immunization coverage. The OK By One Project offers a simplified immunization schedule, accepted by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), that allows completion of the primary vaccination series by the one-year-old well child visit.

Additional strategies to improve immunization rates included Immunization staff conducting immunization audits in 692 child care centers and providing immunization coverage assessments for over 70% of state practices enrolled in the Vaccines for Children (VFC) Program. In addition, increased emphasis on AFIX has been implemented. AFIX is a proven method of practice level improvement to raise immunization coverage levels and improve standards of practices at the provider level. The acronym for this strategy stands for Assessment of provider's vaccination levels, provision of Feedback and strategies to providers, Incentives to recognize improvement and Exchange of resources and information.

MCH continued to review immunization status of children during MCH Program Review visits to

county health departments and contractors. This quality improvement activity provided county and contract staff with the opportunity to ask questions and explore local opportunities for improving immunization practices with state staff.

MCH also continued to serve as a resource to OSDH Immunization Advisory Committee members at quarterly meetings held during the year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained policy of providing immunization to any child presenting at a county health department for immunizations				X
2. Assisted families with insurance coverage to link with the child's primary health care provider for immunizations		X		
3. Maintained contract with the Oklahoma Health Care Authority, the state Medicaid agency, for reimbursement of immunizations and support of the electronic state immunization registry (OSIIS)				X
4. Supported statewide efforts of the "OK by One" Project to facilitate improvement in vaccine protection levels		X		
5. Monitored immunization services provided through site visits to service providers to assure children receiving immunizations on schedule				X
6. Served as resource to Oklahoma State Department of Health (OSDH) Immunization Advisory Committee				X
7.				
8.				
9.				
10.				

b. Current Activities

Oklahoma continues to place a strong emphasis on targeting pockets in need of immunization services. Population-based immunization surveys are conducted in all 77 counties and shared with key county health officials to enhance rates. County and state survey results consistently identify issues of getting infants vaccinated on time and on schedule. The OK by One Project, child care center audits and AFIX are being used to impact this finding.

OSDH Immunization Field Consultants (IFC) continue to complete immunization audits in child care centers. Staff are working with centers to raise vaccine protection levels with a follow-up visit to centers falling below the 90% coverage level. Immunization representatives continue to target public and private clinics to be the recipients of CDC's AFIX intervention.

Oklahoma is launching a new intervention, "Operation Buzzer Beater: Last Second Shots". The new strategy will target the estimated 12% of children at age 22 months who are lacking one dose to complete the primary series.

Provider participation in the OSIIS increased during the year from 768 to 871, and 1,139 schools and 208 child care centers utilize the registry for tracking state immunization requirements. Participation should increase further with the OHCA requiring providers serving children to participate in the VFC Program and the OSIIS as part of the terms of their contracts being initiated/renewed for this next year.

c. Plan for the Coming Year
MCH will continue its close partnership with Immunization Service and support activities targeted toward attaining the goal of 90% of children up-to-date with the primary series of immunizations by their second birthday. Activities will continue to focus on support and evaluation of the OK By One Project, improved vaccination of child care attendees, clinic-level quality improvement and Operation Buzzer Beater. Efforts will continue to expand private sector partnerships with business and medical communities to promote the health of children. MCH will collaborate with the Immunization Service as part of an OSDH workgroup to establish a pilot for billing private insurance companies for children with private insurance served by public health clinics.

The OSDH will maintain its policy of providing immunizations to any child that presents at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations are provided to an insured child, county staff will work with the parent/guardian to link the child with his/her primary health care provider for future immunizations.

A contractual agreement will remain in place between the OSDH and the OHCA allowing reimbursement for immunization services received through the county health department system for children covered by Medicaid. In addition, a contractual agreement will remain in place allowing reimbursement for Medicaid administrative costs related to the OSIIS.

MCH will continue to participate as an ex-officio member of the OSDH Immunization Advisory Committee.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	28	27.3	31.4	27.1	26.8
Annual Indicator	31.9	27.4	30.4	30.4	30.5
Numerator	2145	2020	2281	2293	2268
Denominator	67198	73677	75011	75486	74346
Data Source					OSDH vital statistics & U.S. Census Bureau.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	29.5	29	28.5	28

Notes - 2008
Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau.

Notes - 2007

Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau.

Notes - 2006
Source: Health Care Information, OSDH.

Objectives for 2007-2011 have been revised to reflect more plausible targets given recent data from Oklahoma vital statistics.

a. Last Year's Accomplishments
Oklahoma's 2007 teen birth rate for adolescents aged 15-17 years remained unchanged from 2006 at 30.4 live births per 1,000 females. For the most recent year National Center for Health Statistics (NCHS) final birth data was available, Oklahoma's 2007 birth rate of 30.4 for 15-17 year olds was 36.9% higher than the national rate of 22.2. Of the 7,616 infants born in 2007 to females 19 and younger, 2,386 infants or 31.3% were born to mothers 17 years of age or younger and 5,230 infants or 68.7% were born to mothers eighteen and nineteen years of age. In 2007, sixty-one of Oklahoma's 77 counties had teen birth rates higher than the 2005 national average of 21.4 per 1,000 females age 15 to 17.

MCH continued to place an emphasis on building infrastructure and supporting adolescent health services statewide. The MCH Adolescent Health Coordinator attended a two-day training sponsored by the Maternal and Child Health Bureau (MCHB) funded State Adolescent Health Resource Center at the University of Minnesota. This training provided information to state MCH programs on how to build support for adolescent health, internally and externally.

In June 2008, the Adolescent Health Coordinator facilitated completion of the Adolescent Health System Capacity Assessment with support of staff from the State Adolescent Health Resource Center(SAHRC)/Kanopka Institute for Best Practices in Adolescent Health, University of Minnesota. The purpose of the internal assessment was to assess the Oklahoma State Department of Health's (OSDH) organizational commitment and capacity for adolescent health in six key areas: 1) Commitment to adolescent health; 2) Partnership; 3) Program planning and evaluation; 4) Data and surveillance systems; 5) Education and technical assistance; and, 6) Policy and advocacy.

The Adolescent Health Coordinator initiated a train-the-trainer program, "Parents, Let's Talk", taken from the Advocates for Youth educational campaign. The training was offered as a one day training with emphasis on healthy youth development, understanding adolescent brain maturation and what teens need, internet safety, asset building, human immunodeficiency virus and sexually transmitted diseases (HIV/STDs) information and how to talk to youth about sexuality.

The Interagency Coordination Council (ICC) for Prevention of Adolescent Pregnancy and STDs, a legislatively appointed interagency group, continued to meet. Key activities centered around educating legislators and local school district administration as to Oklahoma's poor statistics on adolescent pregnancy and STDs and the need for additional resources to be provided in efforts to improve adolescent health.

Adolescent parenting projects that provided clinical and population-based services in both Oklahoma City and Tulsa continued to be funded by MCH. The projects focused on healthy birth outcomes, school completion and delay of subsequent pregnancy.

Five state-funded adolescent pregnancy prevention projects continued to be administered through MCH, two in county health departments and three in community-based private nonprofit organizations. Activities of the projects focused on middle school populations. Four additional adolescent pregnancy prevention projects in targeted areas of greatest need in the state were implemented by MCH as a result of a $500,000 appropriation by the state legislature. These funds were used to implement the "Postponing Sexual Involvement" curriculum in middle schools

as specified in the legislation.

Tulsa Youth Services continued a project of outreach and education to hard-to-reach/at-risk youth in Tulsa County using federal Title X family planning funds received through a contractual agreement with MCH. Youth identified as low-income, alternative lifestyle, uninsured and/or at-risk of poor health outcomes received preventive health education and were assisted in linking with additional social and health care services as needed.

Family planning clinical services continued to be provided to adolescents through county health departments and contract providers. These services included a comprehensive physical examination, preventive education on HIV and STD transmission, education on contraception methods (including abstinence) and encouragement of parental involvement.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Completed Adolescent Health System Capacity Assessment				X
2. Initiated a train-the-trainer (Parents Let's Talk) on healthy youth development, adolescent brain maturation, safety, etc.				X
3. Participated in the activities of the Interagency Coordinating Council (ICC) for Prevention of Adolescent Pregnancy and STDs to facilitate systems/policy changes				X
4. Supported teen pregnancy prevention projects, teen parenting programs and male involvement project			X	
5. Provided clinical family planning services through county health departments and contract providers	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The findings of the Adolescent Health System Capacity Assessment were analyzed and summarized in a report received in December 2008 and is being used to develop a quality improvement plan to strengthen the OSDH's capacity to address the health issues of Oklahoma's adolescents.

Additional federal Title X family planning funds were received to implement two special projects, one in Oklahoma County and one in Tulsa County. These projects are focused on providing outreach, education and family planning clinical services to the African American population. With Oklahoma's African American population having more than twice the infant mortality rate of the white population and high rates of adolescent births, MCH engaged their federal Title X Project Officer in discussions with results being the receipt of these additional funds.

The Adolescent Health Coordinator has developed an educational presentation on the adolescent brain and implications for provision of social services, education and health care services to youth. Requests for the presentation are being received routinely from public and private partners.

State funds for the two adolescent parenting projects and the PSI projects were eliminated in the state fiscal year (SFY) 2010 appropriations to the OSDH. Contracts for these services will not be

renewed due to lack of state and federal funds.

c. Plan for the Coming Year

MCH will be exploring with key stakeholders to include the ICC for Prevention of Adolescent Pregnancy and STDs and the Oklahoma Institute for Child Advocacy strategies to lessen the impact of the state budget cuts to services for adolescent pregnancy prevention. In addition to the cuts made by the state legislature to specific funds for these projects, the legislature also cut state general revenue funds to the OSDH. With these cuts, OSDH Leadership has made administrative decisions to utilize state funds from two county health department adolescent pregnancy prevention projects that are currently inactive with their project coordinator positions vacant as well as funds from the state position that monitors the adolescent pregnancy prevention projects toward addressing the agency's budget deficit for SFY 2010. This is requiring MCH to realign funds to support the state position that is critical to providing technical assistance and monitoring of the remaining projects.

MCH continues to utilize the information from the Adolescent Health System Capacity Assessment in planning toward development of a state plan for adolescent health. This plan will include specific goals, objectives, activities and markers for ongoing system evaluation to include adolescent pregnancy prevention.

MCH will utilize data from sources such as vital records, Medicaid and the Youth Risk Behavior Survey (YRBS) in continuing to emphasize to state policymakers the negative consequences of adolescent pregnancy and the need to reassess the funding cuts to these services. MCH will prioritize requesting reestablishment of state funds for the PSI projects in the OSDH SFY 2011 budget request to the state legislature.

The multi-year agreements for the remaining five state general revenue funded adolescent pregnancy prevention projects end June 30, 2010. MCH will be developing a request for proposals (RFP) that will be released in January 2010 for response by interested community organizations. Use of the PSI curriculum in middle schools will be a priority within the RFP requirements.

Efforts to promote positive youth development will be strengthened by the Adolescent Health Coordinator and School Health Coordinator in their interactions and guidance to school health nurses working with middle school students across the state.

MCH will explore use of MySpace and Facebook as ways to provide preventive health education to adolescents. Input will be sought from adolescents on how to improve access to and information on MCH web pages as well as suggestions on other means to communicate more readily and effectively with youth.

Title X family planning services will continue to be provided to adolescents requesting services at county health departments and contractors.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	40	41.2	37.7	38.7	39.6
Annual Indicator	32.9	36.8	34.4	35.1	39.7

Numerator					
Denominator					
Data Source					Oklahoma Oral Health Needs Assessment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40.2	40.7	41.3	41.8	42.3

Notes - 2008
Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.

Notes - 2007
Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.

Notes - 2006
Source: Statewide Oklahoma Oral Health Needs Assessment, 2006 - Dental Health Service, OSDH.

Objectives for 2007-2011 have been revised to reflect more attainable targets given data from the dental needs assessment.

a. Last Year's Accomplishments
The sixth annual statewide dental health needs assessment of third grade children was conducted. The Oklahoma State Department of Health (OSDH) Dental Health Service contracted with the University of Oklahoma (OU) College of Dentistry to administer the dental needs assessment and worked with the OU College of Public Health's Department of Biostatistics and Epidemiology to determine the sample design and to perform the data analysis. Data from the 2008 dental survey revealed: the percent of third grade children having protective sealants on at least one permanent molar tooth was 39.7%; the percent of third grade children having dental caries experience was 72.0%; and, the percent of third grade children having untreated dental decay was 32.7%.

The Oklahoma Dental Loan Repayment Program became effective in November 2006 with permanent rules adopted by the Board of Health in March 2007. This program was designed to increase the number of dentists serving and caring for those dependent upon Medicaid for dental care and to make dental care accessible to underserved metropolitan and rural areas. The program provided educational loan repayment assistance for up to four Oklahoma licensed full-time dentists and one full-time equivalent faculty dentist per year, for a 2 to 5 year period per dentist. Ten practicing dentists and one faculty dentist were participating in the program during this period. The Dental Health Service administered this program.

The state legislature appropriated $100,000 to OSDH to help support the Oklahoma Dental Foundation Mobile Dental Care Program. Using this mobile dental unit, comprehensive dental treatments were provided to clients who could not afford dental care and/or who lived in underserved areas of the state. These funds were administered through the Dental Health Service. Between October 1, 2007 and September 30, 2008, 82 trips were made to locations within Oklahoma, 1,590 volunteer hours were provided to treat 870 patients, and the value of the care provided was estimated to be $213,399. Of those 870 patients, approximately 67% were

children under the age of 18; 61% of those were children eight years old or younger.

MCH continued to work collaboratively with Dental Health Service to educate children, their parents/guardians and health care providers on oral health, to include the importance of protective sealants. Child health providers assessed teeth during well child exams and referred as indicated. The OSDH School Health Program distributed oral health education material via schools, newsletters and conferences.

Dental educational services provided by dental health educators included dental health education and tobacco use prevention instruction in 38 counties to 39,997 children, preschool through high school, with an emphasis on reaching those in kindergarten through sixth grades. Topics included appropriate dental hygiene and care of one's teeth, playground safety, the use of mouth guards, dental disease prevention (sealants, fluoridation, regular dental care) and proper nutrition with healthy snacks.

Six county health department clinic sites provided dental services to children. Procedures and services included dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction and prescriptions for infections. MCH continued to provide funding for dental clinical services as well as partial funding for the statewide dental needs assessment.

Member appointments were made to the Governor's Task Force on Children and Oral Health and the first meeting was held on September 5, 2008. This task force was charged with determining ways to infuse oral health education, dental care and dental disease prevention into existing programs for children and youth to include those with special needs, recommending new programs and developing a state oral health plan.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted the sixth annual statewide dental health needs assessment of third grade children				X
2. Supported the placement of dentists in rural areas of state through educational loan repayment program funded through the Oklahoma Dental Loan Repayment Act				X
3. Provided comprehensive dental care to children who could not afford care and/or live in underserved areas of the state through partnership with Oklahoma Dental Foundation	X			
4. Provided assessment of teeth and dental health education at child health exams provided through county health departments and contractors	X			
5. Provided dental health education in schools			X	
6. Provided dental clinic services through 6 county health department sites	X			
7. Participated in Governor’s Task Force on Children and Oral Health to improve dental services for children				X
8.				
9.				
10.				

b. Current Activities

A report of the 2008 statewide dental health needs assessment of third grade children is finalized. Dental Health Service worked with the OU colleges of Dentistry and Public Health to complete

this project. Information obtained from this survey includes dental caries and sealant data.

The Oklahoma Dental Loan Repayment Program continues to be funded with state appropriated funds. Applications are under consideration for participation in the program for the next state funding cycle.

The Governor's Task Force on Children and Oral Health is in its final phase. The task force is determining ways to infuse oral health education, dental care and dental disease prevention into existing and new programs. Focus areas include fluoridation status of our state, dentistry's role in catastrophic health emergencies and children with special health care needs. This collaborative effort will result in the development of a state oral health plan.

Between October 1, 2008 and March 31, 2009, the Oklahoma Dental Foundation Mobile Dental Care Program made 34 trips to locations within Oklahoma, 169 dental providers donated their time, 421 patients were treated, and the value of the care provided is estimated to be $111,925. Activities continue and the program has received state financial support again for state fiscal year (SFY) 2010.

Dental educational services in 36 counties and dental clinical services in six county health department clinics continue in the state.

c. Plan for the Coming Year

The dental health needs assessment of third grade children will resume in 2010 and be conducted during the even years. This is due to several reasons including staff constraints, time needed for data analysis and evaluation as well as the OSDH having six consecutive years of data to evaluate.

An Oklahoma Mission of Mercy (MOM) is being planned for February 2010 in Tulsa. This statewide event will involve hundreds of volunteers and provide dental services to a large number of needy Oklahomans.

MCH will assure that oral health is addressed through child health clinics, school health activities and the state plans for early childhood and Head Start. The state level Child Health Advisory Task Force, chaired by staff from the Oklahoma Health Care Authority and the Chief of MCH, will work with the Chief of the Dental Health Service and the Child Health Committee of the Oklahoma Health Improvement Plan (OHIP) on strategies to strengthen integration of children's dental health into medical home activities. The OHIP is a SFY 2009 legislative mandate that designates the OSDH as the lead agency responsible for developing a plan to improve the overall health status of Oklahomans and report progress to the state legislature.

Dental educational program services and dental clinical services will continue. Educational topics will include appropriate dental hygiene and care of one's teeth, playground safety, the use of mouthguards, dental disease prevention (sealants, fluoridation, regular dental care), and proper nutrition with healthy snacks. Clinical services will include dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction and necessary prescriptions for infections.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	4.5	3.7	5.5	5	5
Annual Indicator	5.8	4.9	6.7	5.9	5.9
Numerator	41	36	49	44	44
Denominator	712680	727415	735666	745170	745170
Data Source					Vital records & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.7	5.5	5.3	5.1	4.9

Notes - 2008
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Provisional 2007 data is used until 2008 deaths are finalized

Notes - 2007
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Provisional 2007 data used for numerator.

Despite the increase in the death rate of children <15 years of age to motor vehicle crashes in 2006, future rates are expected to remain closer to 5 deaths per 100,000.

Notes - 2006
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator.

a. Last Year's Accomplishments
In 2007, the latest year for which final mortality data are available, there were 44 recorded motor vehicle deaths to children 14 years of age or younger. This resulted in a death rate of 5.9 per 100,000 children in this age group and a decrease from the previous year's rate of 6.7 per 100,000. This should be interpreted cautiously due to the small number of events, which tends to cause volatility in single-year rates. Single-year rates for this measure have varied considerably, making interpretation difficult. The five-year average removes some of this variability. The rate for 2003-2007 was 5.1 per 100,000.

The Child Death Review Board continued to assess multiple variables leading to the death of children including motor vehicle crashes and to make legislative and procedural recommendations as a result of deaths reviewed. The Chief of MCH continued to serve on the Child Death Review Board. The Child Death Review Board instituted a statewide media campaign, "Think, Prevent, Live". Motor vehicle deaths were one of five priorities to be highlighted as part of the campaign.

Safe Kids Oklahoma (Safe Kids) continued as a collaborative project between the Oklahoma State Department of Health (OSDH), University of Oklahoma (OU), Children's Physician's, Children's Hospital at OU Medical Center, Oklahoma Highway Safety Office and Safe Kids Inc.,

the private non-profit fund-raising arm of Safe Kids Oklahoma MCH maintained a contractual agreement with Safe Kids and worked closely with the organization to strengthen its infrastructure with specific focus on administrative and fiscal policies and procedures as the Executive Director and Coordinator positions experienced turnover and new staff were hired. The contract was rewritten to place an emphasis on Safe Kids building local coalitions across the state.

Safe Kids continued to work with the Child Care Licensing Division, Oklahoma Department of Human Services (OKDHS), in the requirement of child passenger safety (CPS) training for all child care centers that transport children. Each center is required to have at least one staff member who transports children complete the eight-hour CPS course. Safe Kids provided oversight for this regulation and worked with the OKDHS to produce a video for child care providers explaining the transportation requirements.

Safe Kids continued to offer training statewide in CPS, primarily targeting health professionals, child care professionals, law enforcement and firefighters. Ten "Introduction to CPS" classes were conducted for 160 participants across the state. One update class was conducted for 32 participants and one four-day certification class was held for 18 participants. Safe Kids staff held 10 one-day classes to educate a total of 160 child-care providers, health educators, firefighters, emergency medical system (EMS) staff and home visitation nurses from the Children First Program on the new OKDHS rules for the transportation of young children by child care providers.

The Safe Kids' Please Be Seated Project allowed concerned citizens to report, via postcard, vehicles carrying unrestrained children. As a result, 732 reported violators were contacted by mail and provided information on the importance of car seats and resources for low cost and no cost car seats.

Safe Kids conducted 26 child safety seat checks across the state, checking a total of 398 seats. An additional 73 safety seat checks were conducted through individual appointments. Safe Kids provided 10 discounted car seats, 292 subsidized car seats and 254 free car seats to the public. The loaner program for children with special health care needs served 89 children. This represents a decrease in numbers served from last year, which can be attributed to staff turnover.

Quarterly meetings continued between MCH and OSDH Injury Prevention Service. All staff from the two areas attended the meetings, which were co-facilitated by the Chiefs of the two areas. The meetings provided a forum for discussion of common interests and collaboration to increase opportunities for effective results, to include the priority of infant mortality and morbidity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in Child Death Review Board to contribute to/impact state policy				X
2. Supported statewide injury prevention education activities of Safe Kids Oklahoma			X	
3. Continued partnership and quarterly meetings with OSDH Injury Prevention Service to enhance injury prevention policy and services				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
One of the workgroups created this year as part of the work of the Commissioner's Action Team on Reduction of Infant Mortality is focused on injury prevention. This workgroup meets routinely to focus on the reduction of mortality and morbidity of infants up to one year of age, to include those resulting from motor vehicle crashes.

MCH continues to provide support and serve as a resource as the new staff at Safe Kids look to increase the presence of Safe Kids activities at the community level across the state.

Train-the-trainer efforts are ongoing through the MCH Adolescent Health Coordinator. These trainings focus on the adolescent brain and maturation, youth development and indicators of morbidity and mortality in Oklahoma (including unintentional injury and death - most commonly motor vehicle accidents). Oklahoma has seen deaths of children 14 years and younger from their driving in rural Oklahoma or riding as a passenger with older adolescents.

MCH and Injury Prevention Service are exploring ways to better communicate information on Oklahoma's Graduated Drivers License to assure adolescents and adults are aware of restrictions related to youth passengers. MCH has strong representation on youth serving task forces and coalitions targeting the prevention of motor vehicle crashes and subsequent injury and death for youth as a result of alcohol use.

c. Plan for the Coming Year
MCH, Injury Prevention Service, the OSDH Office of Child Abuse Prevention and the OSDH Office of Communications will work closely with the Child Death Review Board as the materials for this focus area within the "Think, Prevent, Live" campaign are developed. The Injury Prevention Workgroup, Commissioner's Action Team on Reduction of Infant Mortality will look at how it can build upon this media campaign as it refines its intervention efforts.

The Chief of MCH will serve as the Vice Chair of the Child Death Review Board. This opportunity will provide for additional partnerships in addressing this performance measure.

The Adolescent Health Coordinator will represent MCH on the statewide Injury Prevention Advisory Council. Responsibilities include reviewing proposed legislation and making recommendations as to the potential improved or adverse motor vehicle or highway implications for children.

Strengthening Safe Kids activities at the community level will continue to be a priority for MCH. MCH and Safe Kids will explore with Turning Point opportunities for prioritizing and integrating Safe Kids activities as part of local coalition agendas. Safe Kids will look to increase support given to rural technicians that have participated in CPS training.

MCH and Injury Prevention Service will continue to strengthen their partnership. Routine joint staff meetings will continue. These meetings will provide opportunities for discussion as the comprehensive 5 year needs assessment is finalized for the Title V MCH Block Grant. Injury Prevention Service will support this MCH priority by providing free child safety seats to eligible families and conducting safety seat checks. Child safety seats will be shipped to 67 county health department locations. Injury Prevention Service will maintain in-kind support to Safe Kids for CPS classes, child safety seat check events and technical assistance to strengthen and expand services to rural areas.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			31.8	32.4	33.1
Annual Indicator		31.2	29.6	30.2	30.2
Numerator				14416	14416
Denominator				47662	47662
Data Source					Oklahoma TOTS survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30.7	31.2	31.7	32.2	32.7

Notes - 2008
Source: 2008 data unavailable, therefore 2007 TOTS survey data is used. Numerator and denominator are weighted population estimates. Oklahoma 2007 TOTS surveyed mothers who completed 2005 PRAMS survey.

Notes - 2007
Source: Oklahoma 2007 TOTS survey of mothers who completed 2005 PRAMS survey. Numerator and denominator are weighted population estimates.

Notes - 2006
Data for NPM#11 were obtained from the National Immunization Survey, 2004.

a. Last Year's Accomplishments
2007 data from The Oklahoma Toddler Survey (TOTS), which provides state-specific information on breastfeeding at six months postpartum, revealed 30.2% of Oklahoma mothers breastfed their infants to at least 6 months of age and 11.0% breastfed for 12 months or longer.

MCH monitored breastfeeding initiation, duration and exclusivity using data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC), TOTS and National Immunization Survey (NIS). This information was shared with state policymakers, health care providers, families and community groups.

MCH provided leadership for the Oklahoma State Department of Health (OSDH) initiative recognizing breastfeeding friendly employers and worksites. Employer brochures with minimum criteria for recognition, decals stating that nursing mothers and babies are welcome in Oklahoma businesses and legislation cards summarizing Oklahoma's Breastfeeding Laws were posted on the OSDH Breastfeeding Information and Support web page. One hundred and twenty-five decals were requested for display. Six worksites met established criteria and received certificates as Oklahoma Recognized Breastfeeding Friendly Gold Star Worksites.

MCH and OSDH Human Resources incorporated information about the OSDH breastfeeding room into new employee orientation. The breastfeeding room was showcased to other state and

community agencies as a model of how to set up a room and the benefits it provided to the employer and families in supporting breastfeeding mothers returning to work.

MCH and WIC worked with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to develop Medicaid policy and establish procedures for reimbursement of certified lactation consultant services. OSDH leadership established a skills-based pay incentive for employees obtaining certification or recertification as International Board Certified Lactation Consultants (IBCLCs).

WIC, with the United States Department of Agriculture (USDA) Southwest Region Breastfeeding Workgroup, developed education bags for breastfeeding moms to increase breastfeeding rates. Bags included guidelines for deciding to breastfeed, books, pamphlets for dads and grandparents, DVDs, burp cloths and counseling/talking points for staff.

MCH participated in the WIC Breastfeeding Task Force to develop the pamphlet, Mother's Milk-It's more than just food. The task force planned the "WIC 8th Annual Breastfeeding Symposium for Healthcare Providers, Mother Support: Going for the Gold" and the pre-symposium breast pump training. Additionally, the task force helped create breastfeeding public service announcements, aired during and after World Breastfeeding Week (WBFW) with $313,660 donated airtime. WIC clinics hosted receptions honoring breastfeeding moms, organized walks and stroller derbies at local parks, displayed and shared promotional posters and materials and offered ways to support breastfeeding mothers in breastfeeding classes.

WIC's Breastfeeding Peer Counseling Program expanded to include 14 peer counselors working in 11 sites in nine counties. Since inception, initiation rates increased from 63.3% to 74.4%, above the state WIC average of 71.8%.

MCH along with WIC and 60 partner organizations participated in the effort led by Chronic Disease Service to develop the Oklahoma Physical Activity and Nutrition State Plan (OKPAN), GetFit EatSmart. A September news conference outlined the statewide effort. Strategies were developed in five focus areas, including breastfeeding. Objectives focused on increasing breastfeeding duration were developed for worksites (including schools and child care facilities), healthcare systems and the community/environment.

The Commissioner's Action Team on Reduction of Infant Mortality formalized a Breastfeeding Workgroup to promote breastfeeding. Activities targeted African American and Native American women and teens and included a breastfeeding message "Strong & Healthy Begins With Breastfeeding", promotion and support for creation of an IBCLC staffed Oklahoma Breastfeeding 24-hour Hotline, a breastfeeding brochure for the public, Nursing Your Newborn, coordination with the Coalition of Oklahoma Breastfeeding Advocates (COBA) to explore increasing breastfeeding education in health profession training programs, and posting breastfeeding promotion and education materials on the OSDH Breastfeeding web page.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided information/data about breastfeeding in Oklahoma to wide audience across the state to promote breastfeeding			X	
2. Provided for recognition of breastfeeding friendly employers and worksites facilitating public support and education			X	
3. Served as role model for other state and community-based agencies on work place policy for breastfeeding				X
4. Collaborated with Oklahoma State Department of Health (OSDH) WIC and the Oklahoma Health Care Authority on policy				X

and procedures for Medicaid reimbursement of certified lactation consultant services				
5. Collaborated with WIC to support development of OSDH policy and procedures for skill-based pay incentives for employees who obtain/maintain International Board Certified Lactation Consultant (IBCLC) certification				X
6. Collaborated with WIC in expansion of Breastfeeding Peer Counselor Program		X		
7. Collaborated with WIC and OSDH Chronic Disease Service on breastfeeding training and education activities for providers				X
8. Formalized Breastfeeding Workgroup with focus on activities to reduce infant mortality				X
9.				
10.				

b. Current Activities

MCH and WIC have a strong relationship. Due to this relationship, Oklahoma's Breastfeeding Hotline, a 24/7 statewide breastfeeding support line was implemented in late December. The support line (1-877-271-MILK), a partnership of MCH, WIC, the University of Oklahoma (OU) Medical Center and OU Health Sciences Center Department of OB/GYN, is staffed with IBCLCs and is being promoted to all Oklahoma breastfeeding mothers, expecting parents and health care providers as a resource for support and information.

The OHCA has posted on their website a listing of twenty-one Oklahoma IBCLC providers that have contracts with Medicaid for provision of lactation support services to pregnant and postpartum females. This new benefit is being shared with health care providers through their professional organizations as well as direct provider communications from the OHCA.

MCH, WIC and Chronic Disease Service worked with the COBA to finalize and distribute a model hospital policy on breastfeeding to hospitals participating in the Perinatal Continuing Education Program (PCEP). The OSDH Breastfeeding web page serves as a statewide breastfeeding resource, with recent additions of a "What's New" page, the Oklahoma Breastfeeding Hotline information and number as well as the model hospital policy on breastfeeding.

c. Plan for the Coming Year

Breastfeeding rates will continue to be monitored through PRAMS, WIC, TOTS and NIS data and information shared with state policymakers, healthcare providers, families and community groups to promote and foster the success of breastfeeding.

MCH and WIC will maintain support for the 24/7 Oklahoma Breastfeeding Hotline. The support line will be promoted during training of health care professionals, services to pregnant and breastfeeding females and through the media. MCH will work with WIC to identify sites for possible expansion of the Breastfeeding Peer Counseling Program.

MCH will promote the OSDH Breastfeeding Friendly Worksite Initiative, showcasing qualifying worksites in Turning Point's Certified Healthy Business e-mails and annual conference, the Oklahoma Healthy Mothers Healthy Babies annual conference, the OSDH Breastfeeding web page, the annual WIC Breastfeeding Symposium and through statewide news releases.

The OSDH Breastfeeding web page will be updated regularly (e.g., Frequently Asked Questions, Just 4 Teens and Tips for Success; a two page multicultural breastfeeding brochure, Nursing Your Newborn).

MCH, WIC and Chronic Disease Service will work with the COBA on initiatives to include

monitoring compliance with House Bill 2358 (breastfeeding working mothers), statewide distribution of the model hospital policy on breastfeeding, development of standard protocol/tools to provide technical assistance to hospitals implementing the policy and promotion of outpatient lactation services.

Discussion with the OHCA will explore how Baby-Friendly designation of hospitals may be achieved in the state. Additionally, work will be accomplished on how to move forward Medicaid policy change to extent outpatient lactation benefits from mother to infant so services can be provided to breastfeeding infants older than 60 days.

MCH will work with WIC's Breastfeeding Task Force to plan the 2010 Tenth Annual WIC Breastfeeding Symposium. The task force will coordinate World Breastfeeding Week activities, review breastfeeding promotional materials for county health departments and area clinics and plan for upcoming trainings, including the Breastfeeding Educator Course, Breast Pump Training and the Lactation Exam Preparation Course for health professionals.

MCH will work with the Perinatal Continuing Education Program (PCEP) and the OHCA to offer continuing education to physicians, nurses and other healthcare professionals providing perinatal services in hospitals and outpatient settings statewide. MCH, WIC, Chronic Disease Service and COBA will collaborate to offer lactation trainings and technical assistance for physicians, nurses, social workers, health educators and nutritionists in county health departments and contract clinics.

As part of the Commissioner's Action Team on Reduction of Infant Mortality, the Breastfeeding Workgroup will integrate efforts with existing partners to assure a statewide effort to positively impact infant mortality.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	93.5	96.6	97.2	95.1	95.5
Annual Indicator	93.8	94.6	95.1	95.1	96.8
Numerator	47989	49001	51352	52262	52012
Denominator	51157	51775	54010	54946	53731
Data Source					Screening and Special Services, OSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97	97.2	97.4	97.6	97.8

Notes - 2008

Source: Data were obtained from Screening and Special Services, OSDH. Year 2008 data are provisional estimates.

By 2011 auditory screening machines will electronically transmit results from hospital newborn screenings to OSDH database, which will reduce clerical errors and thus increase the reported % of newborns receiving hearing screenings .

Notes - 2007
Source: Data were obtained from Screening and Special Services, OSDH. Year 2007 data are not yet available. Therefore, year 2006 is repeated to provide an estimate.

Notes - 2006
Data were obtained from Screening and Special Services, OSDH.

a. Last Year's Accomplishments
Of the 54,946 Oklahoma births in calendar year (CY) 2007, 52,262 infants (95.1%) had hearing screened prior to hospital discharge; 2,684 were not screened. Of the infants screened, 2,637 (5.0%) were referred for diagnostic assessment because they did not pass the hospital screening. Of the infants who were referred, 108 had confirmed hearing loss. The average age at diagnosis was less than three months of age. Due to the presence of hearing "risk indicators," 3,438 infants who passed screening at birth were referred for additional hearing screening when they reached six months of age. At least 89 infants with a diagnosis of hearing loss born in 2008 were enrolled in Oklahoma's 0-3 early intervention program, SoonerStart, or other early intervention programs for infants with hearing loss as of February 1, 2009.

On October 1, 2007, sixty-six (66) Oklahoma birthing facilities with a census of 15 or more births per year were providing physiologic hearing screening. Two new birthing facilities opened and immediately started providing physiologic hearing screening as of September 30, 2008.

MCH and CSHCN continued to partner in support of the Newborn Hearing Screening Program (NHSP). MCH provided Title V federal and state funding to support ongoing statewide newborn hearing screening activities. Both MCH and CSHCN provided technical assistance as needed to include support of education and training of service providers.

With the hearing screening equipment purchased with CSHCN funds in 1999 at the end of its useful life, the NHSP, MCH and CSHCN continued efforts started in 2006 to obtain funding to replace hospital hearing screening equipment. As was the case in 2007, CHSCN did not have available funds to assist in the purchase of replacement hearing screening equipment. The Oklahoma State Department of Health (OSDH) made a legislative request for funding for replacement screeners in both 2007 and 2008. The request was granted in both years; 20 new screeners were received on October 1, 2007 with an additional 39 new screeners to be received in October 2008. With this funding, it was anticipated that all Oklahoma birthing hospitals desiring a replacement hearing screener would have one made available.

The 20 replacement hearing screeners received in October 2007 were provided to the hospitals experiencing the most frequent breakdowns of old equipment. The manufacturer's clinical educator and the NHSP Follow-up Coordinator provided training in the use of the equipment.

With support through the Health Resources and Services Administration (HRSA) funded Universal Newborn Hearing Screening Project (4/05-3/08), a Follow-up Coordinator remained part of the NHSP. This enabled the NHSP to move toward reaching the national goals: that every newborn is screened within their first month of life; that infants with loss are diagnosed by three months and then enrolled in intervention by six months of age. The HRSA grant was re-funded for an additional three years (4/08-3/11) in March 2008. HRSA funds were used to purchase fifteen additional otoacoustic emissions (OAE) screeners placed at early intervention sites across the state. Training was provided for clinicians by health department audiologists.

In January 2008, the National Center for Hearing Assessment and Management (NCHAM) invited a representative from the NHSP, a representative from Oklahoma's Part C Program (SoonerStart) and an Oklahoma pediatrician to a meeting to assist in developing guidelines compliant with confidentiality regulations for sharing information between screening programs and intervention programs. The developed guidelines are available on the NCHAM website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided timely screening for newborn hearing and needed follow-up services statewide			X	
2. Provided education and training for service providers				X
3. Secured funds for replacing hearing screening units approaching the end of useful life				X
4. Developed guidelines with the National Center for Hearing Assessment and Management (NCHAM) for sharing information between screening programs and intervention programs and posted to NCHAM website				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 39 replacement hearing screening units purchased are being provided to hospitals and health department sites. All facilities desiring new hearing screeners will be equipped by the end of the fiscal year.

The NHSP task forces continue their ongoing activities, however because of agency travel restrictions, meetings are being held via telephone conference calls rather than face-to-face meetings. The Screening Task Force is working closely with the 68 birthing facilities to ascertain that birth hearing results are reported to the NHSP promptly and accurately. Plans to place the bloodspot card serial number on the Oklahoma birth certificate are underway to ensure that every newborn received metabolic and hearing screening. With an added capability of the newly placed hearing screening equipment, the possibility of electronically reporting hearing results directly to the NHSP is being explored. The Audiology Task Force continues to review hospital hearing screening protocol to ascertain that it meets the 2007 Joint Committee on Infant Hearing Position Statement recommendations. The Early Intervention Task Force continues to develop outcome measure protocols for infants and toddlers enrolled in early intervention programs.

At the 2009 Early Hearing Detection and Intervention (EHDI) Conference, OSDH audiologists and NHSP staff presented an invited paper on Oklahoma's success in assisting infants with hearing loss with appropriate services in a timely manner.

c. Plan for the Coming Year

The statewide NHSP will continue to seek ongoing support and assistance from the MCH and CSHCN programs. As in the past, the three programs working together will assure that all Oklahoma newborns meet or exceed the national goals of having their hearing screened within

the first month of life, and if hearing loss is suspected, diagnosis and intervention are provided for the infant in a timely manner.

With funding from the HRSA grant, additional hearing screening equipment will be made available to health departments in rural areas. More than 60 sites including health departments and early intervention locations will be equipped and trained to provide follow-up screening for infants who did not pass the hospital screen, were not screened prior to discharge and/or have conditions warranting the need for hearing re-screening at specific intervals. Training in the use of screening equipment will be provided to clinicians as needed by health department audiologists.

Grant funding will also be used to develop a method to make newborn hearing screening and metabolic screening results available to authorized providers (physicians, audiologists and other health care providers) on a secure website. Follow-up screening and diagnostic results will be reported back to the newborn screening programs electronically in a secure fashion.

The NHSP task forces (Screening, Audiology, and Early Intervention) will meet regularly via teleconferencing or face-to-face to address changing needs. The Screening Task Force will be examining ways to ascertain the accuracy of the newborn's demographics. The Audiology Task Force will be recommending changes to the present Oklahoma infant diagnostic assessment protocol as well as providing outreach to state audiologists working with children who have hearing loss. The Early Intervention Task Force will continue to explore ways that the early intervention program can better serve infants/toddlers with hearing loss and their families who reside in rural areas. The group will continue to investigate the possibility of using the OSDH videoconferencing system, an IP based video-teleconferencing network between the state office and most of Oklahoma's county health departments. It is hoped that a family in a rural area will be able to travel only a few miles to a local health department to take advantage of the therapy skills of a master clinician who is at location in another part of the state.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	14	13.7	17.8	13.9	12.4
Annual Indicator	15.3	14.0	12.5	12.5	12.6
Numerator	141860	127190	114000	114000	116000
Denominator	924670	910660	913000	913000	920000
Data Source					U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.5	12.4	12.3	12.2	12.1

Notes - 2008
Sources: U.S. Census Bureau, Current Population Survey.

Notes - 2007
Sources: U.S. Census Bureau, Current Population Survey. Current 2007 data not yet available, therefore 2006 numbers used as an estimate.

The 2008-2012 future annual performance objectives have been revised to a conservative estimate of the % uninsured children given current economic conditions in Oklahoma.

Notes - 2006
Sources: U.S. Census Bureau, Current Population Survey.

a. Last Year's Accomplishments
Data obtained from the U.S Census Bureau revealed that 12.6% of all Oklahoma children ages 0-18 were uninsured during calendar year 2008, higher than the national average of 11.0% of uninsured children ages 0-18. Approximately 116,000 children were uninsured in the state of Oklahoma.

Oklahoma submitted a request to the Centers for Medicare and Medicaid Services (CMS) to expand coverage of children up to 300% of the federal poverty level (FPL) under the State Children's Health Insurance Program (SCHIP). The request was declined by CMS.

During the 2008 legislative session, MCH provided information and education to support passage of several measures to increase access to health care in the state. These measures included provisions of insurance coverage of expenses associated with the treatment of autism, support of the children's behavioral health initiative and increased access to health care through workforce development.

The MCH Early Childhood Comprehensive Systems (ECCS) Project continued to work in collaboration with Smart Start Oklahoma and the Oklahoma Partnership for School Readiness (OPSR) Board to implement the Early Childhood System Model. Working at the local level, eighteen Smart Start Oklahoma communities addressed two of the goals that focus on health insurance: 1) services promoting health are available and accessible to all children; and 2) children have a source of comprehensive, family-centered primary health care. A topic that emerged from the Smart Start strategic planning session this year was "Increasing Access to Healthcare". Much of the discussion focused on how Smart Start communities could be utilized to engage and assist their communities to increase SoonerCare (Medicaid) enrollment. The MCH ECCS Coordinator continued providing staff support to Smart Start Oklahoma in the implementation of the state early childhood plan. The MCH ECCS Coordinator also organized and conducted a child care health consultant training session which included a component on assisting families and child care providers with enrolling in the SCHIP.

MCH continued to work closely with the OHCA and the Oklahoma Department of Human Services (OKDHS) to develop policy and procedure to expand health services to children. County health departments and contract providers provided families with information on health related benefits and assisted families with benefit application completion. MCH continued to partner with the OHCA to facilitate the Child Health Advisory Task Force with its emphasis on the seven priority topics: primary care utilization, mental health, obesity, reimbursement structure, oral health, immunizations and accessing specialty care.

Clinical child health services were provided as a safety net service through county health department sites and MCH contract providers. Services included the provision of well child exams, treatment of minor acute illnesses, follow-up metabolic and newborn hearing screening, lead screening and enabling services as needed. These services were provided in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.

Based on recommendations from the Title V MCH Block Grant Review in August 2008, the Chief of MCH and Director of the CSHCN Program looked to strengthen routine collaboration via face-to-face meetings, support and technical assistance to the network of federally qualified health centers (FQHCs) through recurring meetings facilitated by the Oklahoma Primary Care Association.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided information and education to legislators and their staff to support measures to increase access to health care coverage				X
2. Continued implementation of the Early Childhood Coordinated Systems State Plan which includes goals/activities related to health care coverage				X
3. Linked families with needed Medicaid services through county health departments and MCH contractors		X		
4. Provided clinical health services as a safety net provider through county health departments and contract providers	X			
5. Sought to develop stronger relationship with federally qualified health centers (FQHCs)				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMS has approved Medicaid coverage of children up to the 300% FPL. Options are being explored on how to increase coverage taking into consideration the state's current budget environment. On January 1, the OHCA implemented a new model of service provision moving from a partially capitated program to a medical home model providing fee for service reimbursement. The model has 3 tiers providers choose from to identify the level of medical home they will provide. A set fee is received for care coordination based on the tier chosen.

MCH worked closely with the OHCA to make changes to Medicaid policy this year to adopt the American Academy of Pediatrics Bright Futures periodicity schedule as the standard of practice.

MCH is staffing as well as participating as a member of the Child Health Committee of the Oklahoma Health Improvement Plan (OHIP), a legislatively mandated activity that designates the OSDH as the lead agency responsible for developing a plan to improve the overall health status of Oklahomans. Insurance coverage is one of many issues being addressed through this work.

MCH was notified in June that funding for the ECCS Grant will be reduced this next grant period by 25%. This is resulting in MCH decreasing funding to community-based Smart Start projects.

With multiple contacts made to the Executive Director of the Oklahoma Primary Care Association, MCH and CSHCN are anticipating participation in FQHC meetings will begin by the end of the federal grant period.

c. Plan for the Coming Year

Funding will continue to be provided through the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), ECCS Grant to support implementation of the ECCS state plan. The ECCS Coordinator will continue to work with the OPSR and Smart Start communities providing technical assistance and linkage with needed resources.

The Chief of MCH will continue to co-chair the Child Health Advisory Task Force. A priority of the task force is to assure that information on health care policy to include health insurance coverage is communicated to health care provider and family organizations for sharing through their networks across the state. Input will continue to be sought from the task force members on gaps in coverage and improvements to consider in facilitating families to access the most appropriate coverage. Information will be used in making policy changes with both public and private coverage.

A Consumer Advisory Committee will be formalized by the OHCA. This will provide an additional opportunity for families to provide input into state Medicaid policy. This is a result of family representatives being added to the Perinatal and Child Health task forces based on direct requests of MCH and CSHCN. The OHCA having seen the value of having families actively participate in the task force meetings has subsequently engaged in discussions and planning with the Executive Director of the Oklahoma Family Network to develop the committee.

The Director of the Child and Adolescent Health Division will continue as staff to the Child Health Committee of the OHIP. The Chief of MCH will continue as a member. Outcome and performance measures from the Title V MCH Block Grant will provide a strong basis for the Child Health Committee's plan.

Efforts will continue to engage the FQHCs in more routine interactions so mutual goals and priorities can be enhanced through ongoing sharing of information and collaboration. The Chief of MCH and Director of the CSHCN Program will look to attend quarterly meetings of the FQHC Directors and their clinic administrators as a first step.

MCH and CSHCN will participate in the Oklahoma Institute for Child Advocacy (OICA) Fall Forum scheduled for October 2009. This annual forum brings together advocates from the public and private sectors as well as families from across the state to develop a children's agenda for action during the legislative session. Health insurance coverage is a recurring priority brought forth in the children's agenda.

County health departments and contractors will continue to provide needed gap filling direct health care services to children using the American Academy of Pediatrics Bright Futures Guidelines. Both contractors and county health departments will provide information and assistance to families seeking information on health benefits for children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			50.2	53.9	53.3
Annual Indicator		51.3	54.4	54.4	54.4
Numerator					
Denominator					
Data Source					NCHS SLAITS Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52.3	51.2	50.2	50	50

Notes - 2008
Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged 2-5 receiving WIC benefits. Numerator and denominator data are unavailable. 2008 data not available, hence 2006 numbers used as an estimate.

Note: 2007 SLAITS survey does not ask for WIC participation information - this question was discontinued after the 2003 SLAITS survey.

Notes - 2007
Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged 2-5 receiving WIC benefits. Numerator and denominator data are unavailable. 2007 data not available, hence 2006 numbers used as an estimate.

Notes - 2006
Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged 2-5 receiving WIC benefits. Numerator and denominator data are unavailable.

a. Last Year's Accomplishments
Oklahoma-specific data from the National Center for Health Statistics (NCHS), http://www.cdc.gov/nchs/about/major/slaits/nsch.htm, reveal that 54.4% of children ages 2 to 5 years fall at or above the 85th percentile of the body mass index (BMI)-for-age. This compares to the national average of 57.0%. The proportion of Oklahoma children at risk for overweight or at overweight has increased by 3.1% in absolute terms. The Women, Infants and Children Supplemental Nutrition Program (WIC) reported that the percent of children ages 2 to 5 years, receiving WIC services through the Oklahoma State Department of Health (OSDH) with a BMI at or above the 95th percentile was 13.7% in 2008.

WIC continued to monitor BMI status for children ages 2 to 5 years and required low fat food options for those with a BMI at or above the 95th percentile. In addition, WIC began work to eliminate whole milk from the WIC food package for 2009 for participants over two years of age.

WIC worked to revitalize quality nutrition services and maintained a focus on childhood obesity prevention. Policy, implementation and statewide training for Value Enhanced Nutrition Assessment (VENA) were completed. Oklahoma encouraged the development of healthy weights in WIC families through increased intake of fruits and vegetables and the use of reduced fat dairy products in planned meals. Increased active play and physical activity were also emphasized. Oklahoma WIC nutrition assessment shifted the focus from eligibility determination to a participant centered outcome-based process and improved the program's integrity. "Cooking with WIC" was a continuous series using video field trips and cooking demonstrations to help WIC participants improve their skills in purchasing, planning and preparing nutritious meals and snacks to improve the family diet.

WIC promoted the continued expansion of professional development, education and training of staff through web-based training, online training and local, state and national conferences. The WIC Training Link (www.ok.gov/wic) provided up-to-date online trainings and information to local, state and national WIC staff. The Certified WIC Nutrition Technician (CWNT) Training Program was accompanied by activities, quizzes, and assignments to reinforce the subjects of the course and to develop skills used in the WIC clinic. Policy, procedure and additional trainings were developed to expand the CWNT Training Program (soon to be know as the WIC Training Course) to train and educate all WIC staff: clerical, paraprofessional and professional.

WIC continued to assertively address the promotion of breastfeeding and breastfeeding education to combat childhood obesity. WIC's efforts to promote and support breastfeeding show results with almost a 10% increase in breastfeeding initiation rates in the last 5 years (63% in 2003 to 72.7% in 2008). In addition, the WIC Breastfeeding Peer Counseling Program expanded and succeeded in increasing breastfeeding initiation rates in the counties served by Breastfeeding Peer Counseling Program. Breastfeeding Peer Counselors worked in Lincoln, Logan, Kingfisher, Blaine, Canadian, Comanche, Leflore, McIntosh and Haskell counties. Initiation rates increased from 63.3% in 2004 before implementation to 75.4% in 2008 (see NPM #11).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored body mass index (BMI) status of all children ages 2-5 receiving WIC			X	
2. Required low fat/kcal options for all WIC clients at or above the 95th percentile BMI and worked to improve healthy eating and physical activity emphasis in program	X			
3. Supported breastfeeding as a priority through state planning and training activities				X
4. Expanded Breastfeeding Peer Counseling Program		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Children ages 2 to 5 years, receiving WIC, identified with BMIs = 95th percentile are referred to a registered/licensed dietitian for individual counseling.

New food packages higher in fiber and lower in fat will be implemented in August 2009. In addition, infants will receive baby food while breastfeeding moms will have a larger variety of canned fish. Whole milk will no longer be available for participants two years of age and older and the amount of juice provided will be decreased for children and eliminated for infants.

Breastfeeding continues to be a priority focus area for Oklahoma WIC. WIC hosted a Lactation Review Cram Course in March for the International Board Certified Lactation Consultants (IBCLC) exam. There are currently 7 IBCLCs providing support to breastfeeding mothers in WIC clinics.

WIC hosted the Annual WIC Breastfeeding Educator Course in April 2009. In June 2009 clinic staff and healthcare providers statewide had the opportunity to attend the Annual WIC

Breastfeeding Symposium.

WIC also provides support through the WIC breast pump program. This year WIC has provided a breastfeeding education bag (see NPM #11). Oklahoma WIC has also partnered with MCH in establishing and supporting the new Oklahoma Breastfeeding Hotline.

Presently there are a total of 14 breastfeeding peer counselors working in a total of 11 sites.

Policy and procedures related to registered/licensed dietitian and individual counseling are currently under development.

c. Plan for the Coming Year

The Annual Nutrition/WIC Conference 2010 will address current clinical nutrition practices, as well as other medically complex conditions. WIC will continue to produce a "Cooking with WIC" lesson annually. "Cooking with WIC" is a video lesson plan featuring one of Oklahoma's WIC nutritionists preparing meals and snacks using WIC foods. This will allow clinics to show cooking and meal preparation demonstrations even if their facilities do not allow for these to be performed on site. The 2009 "Cooking with WIC" video lesson plan will detail making full meals with the new WIC food package, including whole grains, beans, fresh fruits and vegetables.

Conclusions from evidence based reports and reviews suggest a history of breastfeeding is associated with the reduction in the risk of obesity in later life therefore breastfeeding will continue to be a priority focus area for WIC. Strategies to increase breastfeeding initiation and duration rates among Oklahoma mothers will continue to be explored, including through the influence of peer support. The Breastfeeding Peer Counseling Program will continue in the existing sites with breastfeeding peer counselors throughout the state. In addition, the Breastfeeding Peer Counseling Program will continue to expand to additional sites in 2009-2010, including the Tulsa Health Department and Oklahoma City County Health Department.

WIC will continue to provide breastfeeding educational opportunities in 2010 to WIC staff and health care providers by hosting the 5-day Lactation Management Course, the Breastfeeding Educator Course and the Breastfeeding Symposium. The Oklahoma Breastfeeding Hotline and the OSDH Breastfeeding web page will continue to be supported and promoted by WIC. WIC also plans to continue to provide breast pumps and breastfeeding education bags to help mothers continue to breastfeed and thus increase Oklahoma's breastfeeding duration rates.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			18.8	18.6	18.4
Annual Indicator		19.6	19.3	21.3	21.3
Numerator		10027	9953	11101	11101
Denominator		51157	51500	52148	52148
Data Source					PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	20.5	20	19.5	19

Notes - 2008
Source: Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2008 have not been released to date. Therefore, PRAMS survey data for 2007 have been used to provide an estimate for this measure. Numerator and denominator consist of weighted counts.

Notes - 2007
Source: Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2007. Numerator and denominator consist of weighted counts.

Notes - 2006
Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) for the year 2006.

a. Last Year's Accomplishments
Monitoring data provided by the Oklahoma State Department of Health (OSDH) Pregnancy Risk Assessment Monitoring System (PRAMS, 2007) show that 21.3% of pregnant women report smoking during the third trimester of pregnancy. This is a slight increase compared with PRAMS data for year 2006 in which 19.3% of pregnant women reported smoking in the last three months of pregnancy. Overall, since year 2000, when it was 16.9%, the rate of smoking during pregnancy has increased in relative terms by 26%. This increase has not been monotonic over this eight-year period and the upward trend is not statistically significant, except among African American women in the state. In 2001, the rate rose to 20.3%, then dropped to 16.2% in 2003, and finally rose again to 21.3% in 2007.

The Oklahoma Health Care Authority (OHCA)/OSDH (MCH) Perinatal Advisory Task Force moved into its third year of facilitating systems changes to improve perinatal care. Based on input received from the task force, a psychosocial risk assessment tool to assess all psychosocial aspects of the woman's life to include tobacco use, a coping mechanism for mental health problems, stress, unstable family dynamics, etc., was developed by MCH and the OHCA. MCH and the OHCA also drafted policy changes allowing Medicaid providers to receive separate compensation for completing the assessment and for counseling patients on the "5 A's" for tobacco cessation.

The Tobacco Workgroup of the Commissioner's Action Team on Reduction of Infant Mortality developed a strategic plan including activities to "Enhance tobacco use prevention activities with pregnant and postpartum females, their families, and health care providers." Activities planned included collaboration with the OHCA to conduct educational presentations for Medicaid providers on treating tobacco dependence, partnering with the OHCA to develop a pilot tobacco cessation project for pregnant and postpartum women and working to expand tobacco cessation benefits to parents who bring children to pediatric appointments. Additional activities included adding questions to The Oklahoma Toddler Survey (TOTS) on exposure to second hand smoke and developing educational tools for pharmacists on tobacco cessation resources.

MCH collaborated with the OSDH Chronic Disease Service during Women's Health Week, May 12-16, and provided a community toolkit with information regarding the effects of substance abuse on women and the effects of smoking on pregnant women and infants to county health departments and on the OSDH website. The toolkit included a sample press release encouraging pregnant women who smoke to quit on Mother's Day 2008 as part of the "Clear the

Air for Mother's Day" campaign.

Family planning clients and pregnant women seen through county health department and contract clinics were provided with information on the impact of smoking during the preconception, interconception and prenatal periods. Women who smoked or reported family members who smoked were referred to the Tobacco Helpline, 1-800-QUIT-NOW, for support in their efforts to discontinue smoking. MCH monitored county health department and contract clinics documentation of smoking intervention for clients who reported using tobacco products.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed psychosocial risk assessment tool for providers which includes tobacco use		X		
2. Worked with Oklahoma Health Care Authority to develop Medicaid policy and procedures for separate provider compensation for completing the psychosocial risk assessment and separate compensation for counseling patients on the 5 A's				X
3. Formalized Tobacco Workgroup, Commissioner's Action Team to Reduce Infant Mortality with focus on activities to reduce infant mortality				X
4. Provided community toolkit and sample press release to county health departments and on OSDH website			X	
5. Provided education to family planning and maternity clients seen through county health departments and contract providers; referred to Oklahoma Tobacco Helpline		X		
6. Monitored referrals of clients through review of documentation in client health records during site visits to county health departments and contract providers				X
7.				
8.				
9.				
10.				

b. Current Activities

In October 2008, the third annual prematurity conference was held. Priority topics included a panel on "Oklahoma Initiatives to Prevent Preterm Birth". The OHCA reported on efforts to acquire funding either through the Tobacco Settlement Endowment Trust (TSET) or state legislative budget request to fund a pilot project to encourage smoking cessation in pregnant and postpartum women. The project would provide incentives to help women quit smoking while they are pregnant and to stay quit during the postpartum period. The conference was held in collaboration with the March of Dimes and the University of Oklahoma (OU) College of Nursing.

MCH participates in the OSDH Protection Team, one of five teams formed to provide recommendations into the development of the Oklahoma State Plan for Tobacco Use Prevention & Cessation. A revised plan to include the goal of reducing the number of pregnant women exposed to secondhand smoke was presented to the Governor's Advisory Committee in November 2008.

MCH and OSDH Tobacco Use Prevention Service meet quarterly to assess current activities and identify opportunities for collaboration. Recently, Tobacco Use Prevention Service received TSET funding for three initiatives to partner with the Oklahoma Department of Insurance, the Oklahoma Hospital Association and the Oklahoma State Department of Mental Health to promote

smoking cessation activities.

c. Plan for the Coming Year

Based on work accomplished in 2009, the Tobacco Workgroup of the Commissioner's Action Team on Reduction of Infant Mortality will move forward with the OHCA to train medical providers on the availability of evidence-based cessation interventions and resources and promote awareness of opportunities for provider reimbursement for tobacco dependence treatment. Activities will also focus on evaluating and updating smoking related questions on ongoing MCH population-based surveillance (PRAMS and The Oklahoma Toddler Survey.)

Through a partnership with the OHCA, MCH will be able to obtain Medicaid administrative match funds to expand the contractual agreement with the Perinatal Continuing Education Program (PCEP) at the University of Oklahoma Health Sciences Center, Department of OB/GYN. Funding will be used to implement a quality improvement project that will develop and implement standardized medical protocols to address issues (e.g., smoking) that place pregnant women and infants at risk of poor outcomes to include infant mortality.

Input from the OHCA/OSDH Perinatal Advisory Task Force will be used as the funding request for a pilot tobacco cessation project for pregnant and postpartum women is resubmitted to TSET. A goal of the project is to move towards families being tobacco free with the first step being cessation of tobacco use with the pregnant woman that is sustained after the pregnancy. The OHCA/OSDH Child Health Advisory Task Force will further explore policy and budget impacts of extending Medicaid tobacco cessation benefits to parents who bring children to pediatric appointments.

MCH will continue to collaborate with Chronic Disease Service and Tobacco Use Prevention Service in regularly scheduled quarterly meetings to discuss factors that impact the health of Oklahoma women and infants, including tobacco use. Joint work will be accomplished between meetings to support common priorities.

Family planning clients seen through the county health departments and contract clinics will continue to be provided with information on the impact of smoking during the preconception and interconception periods and referred to the Tobacco Helpline. Maternity providers will continue to assess pregnant women for smoking through use of the Psychosocial Risk Assessment and provide counseling and referral to the Tobacco Helpline as indicated. MCH will be implementing policy changes for the use of faxed referrals to the Tobacco Helpline in an effort to increase follow-up contact after the initial encounter in a health department or contract clinic. An advantage of this approach is, once the Tobacco Helpline receives the faxed referral, follow-up with the individual is initiated by a trained smoking cessation counselor and is not dependent on the individual to make the first call. MCH will monitor county health department and contract clinics use of the fax referral and provide technical assistance as indicated or requested.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9	8.9	10.1	7.9	9.9
Annual Indicator	12.2	8.0	10.4	7.9	11.5
Numerator	27	19	26	20	29

Denominator	221613	236697	250816	251911	251880
Data Source					Vital Records & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	10.5	10	9.5	9

Notes - 2008
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau.

Notes - 2007
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau.

The 2008-2012 annual performance objectives have been revised to reflect current data.

Notes - 2006
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau.

Objectives for 2007-2011 have been revised to reflect more attainable targets given data from Oklahoma vital statistics.

a. Last Year's Accomplishments
Finalization of the 2008 Oklahoma death data has not been included due to a delay in receipt of out of state records. In 2007, Oklahoma recorded 20 (updated state data) suicide deaths to youth aged 15 through 19, resulting in a suicide death rate of 7.9 deaths per 100,000 population. This is a decrease from 10.4 in 2006. Year over year changes in the suicide rate should be viewed with some skepticism given the small number of events in this category of death. The five-year rate covering 2003-2007 was 10.0 suicide deaths per 100,000 youth aged 15-19.

Trend analysis from the 2003, 2005 and 2007 Oklahoma Youth Risk Behavior Survey (YRBS) indicate no statistically significant change in the percentage of students who made a suicide attempt during the past 12 months, made an attempt plan or seriously considered suicide.

The MCH Adolescent Health Coordinator continued to provide representation on the Oklahoma Youth Suicide Prevention Council. In April 2008, this council was renamed per Oklahoma State Statute to the Oklahoma Suicide Prevention Council in an effort to address suicide in Oklahoma across the life span while assuring that youth suicide continued as a strong focus. The legislation also extended the duration of the council's existence and made modifications to membership and duties of the council. By-laws were developed. Emphasis remained on implementation of evidence-based suicide prevention programs in local communities, tribal organizations and institutions of higher learning for youth ages 10-24, as well as coordination of prevention efforts statewide, strengthening collaboration among key stakeholders, evaluation of effectiveness and development of a sustainability plan. As firearms were the leading method of suicide in Oklahoma (66%), a public awareness campaign concerning suicide methodology

began with widespread dissemination of Means Matter: Suicide, Guns & Public Health, a publication of the Harvard Injury Control Research Center, Harvard School of Public Health.

The Oklahoma Suicide Prevention Council, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Commission on Children and Youth, Integris Mental Health and Oklahoma Systems of Care partnered with The Revolution, an Oklahoma state youth organization, to present the second annual Statewide Listening Conference on September 12, 2008. This event grew out of youth listening conferences, held annually for several years at the local community level, and served as a network of youth and multiple agency advocates in the area of health and safety. Youth presentations included teen depression and suicide, gang violence, Indian youth culture and dating violence.

Mercy Hospital, through the support of the Oklahoma Suicide Prevention Council, continued to provide training for hospital staff, including training for emergency room medical staff in suicide assessment and intervention. Developed by ODMHSAS, MCH and Mercy Hospital, the training is based on the "Question, Persuade, Refer" (QPR) model. Numerous QPR trainings were also provided throughout the state to school personnel, hospital staff, county health department staff, tribal entities and faith-based organizations.

Data from the 2003, 2005 and 2007 Youth Risk Behavior Survey (YRBS) were being used to develop fact sheets illustrating state trends in youth suicide ideation and depression. Plans for dissemination were being developed to assure information was shared with a broad audience of stakeholders to include school personnel, mental health providers and youth serving organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained involvement with the Oklahoma Youth Suicide Prevention Council				X
2. Supported the Oklahoma Youth Suicide Prevention Council's public awareness campaign and 2nd Annual Statewide Listening Conference			X	
3. Provided "Question, Persuade, Refer" QPR trainings throughout the state				X
4. Used Youth Risk Behavior Survey (YRBS) trend data (2003, 2005 and 2007) to begin developing fact sheets on suicide risks and ideation among high school students			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

YRBS fact sheets providing the most recent national and state data on youth suicide ideation and depression have been finalized. The fact sheets have been shared with stakeholders as well as posted on the MCH Assessment web page on the OSDH website under Child and Family Health, Maternal and Child Health: www.health.state.ok.us/.

The Oklahoma Suicide Prevention Council in collaboration with the Oklahoma City Area Indian Health Service, held the Fifth Annual Suicide Prevention Conference on December 16, 2008.

The conference focus was suicide prevention among the Native American population.

The Oklahoma Suicide Prevention Council is currently pursuing established goals of the state plan. These include increasing community capacity to address suicide through delivery of prevention trainings targeting partnership boards including local Turning Point coalitions. Issue briefs are being developed.

Numerous QPR and ASIST (Applied Suicide Intervention Skills Training) efforts continue to be offered and completed throughout the state to school personnel, hospital staff, county health department staff, tribal entities and faith-based organizations. To date, there have been 4000 individuals trained in QPR with over 100 trainers available.

In January, MCH received the System Capacity Assessment final report from the Konopka Institute for Best Practices in Adolescent Health. The report highlights opportunities for collaborations to reduce suicides among Oklahoma adolescents.

c. Plan for the Coming Year

Continued funding provided by the Garret Lee Smith Project's Youth Prevention Grant, through 2011, will be utilized by the Oklahoma Suicide Prevention Council for continued funding of the state Suicide Prevention Initiative and state plan. Council members received Strategic Planning for Suicide Prevention training by the Suicide Prevention Resource Center in January 2009 to realign and strengthen specific goals. Goals will focus on increasing the implementation of evidence-based suicide prevention strategies throughout the state and providing training to local community partnerships to increase community capacity. The ODMHSAS will be the lead agency. The overall goals will be to reduce the number of suicide deaths and to reduce attempts among youth ages 10-24, currently the second leading cause of death for Oklahoma youth and young adults. The MCH Adolescent Health Coordinator will remain active on the Oklahoma Suicide Prevention Council and represent MCH in collaborations with the ODMHSAS for the implementation of the state plan.

The Adolescent Health Coordinator will also continue to collaborate with OSDH Injury Prevention Service and the Council to utilize the Oklahoma Violent Death Reporting System in conjunction with prevention activities. The Adolescent Health Coordinator will also share information from the Adolescent Health System Capacity Assessment final report from the Konopka Institute for use in prevention planning efforts.

Fact sheets featuring YRBS trend data related to suicide ideation and depression will continue to be disseminated in multiple venues throughout the state including school personnel, clinicians, youth advocate groups, parents and policymakers.

The annual Oklahoma Suicide Prevention Conference is scheduled for December 2009. The target audience will include youth service agencies, counselors, social workers, clinicians, nurses and Area Prevention Resource Center personnel.

Collaboration between MCH, the Council and Mercy Hospital will continue in an effort to recognize warning signs of a suicidal individual and establish an efficient referral process. QPR and ASIST efforts will be ongoing to provide targeted training for OSDH advanced practice nurses and public health nurses as well as school nurses, other school personnel, hospital staff, tribal entities and faith-based organizations throughout the state.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	79.1	80.3	75.5	77	83
Annual Indicator	74.0	73.4	82.1	78.6	78.6
Numerator	481	545	724	640	640
Denominator	650	743	882	814	814
Data Source					OSDH Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83.5	84	84.5	85	85.5

Notes - 2008
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2008 data are not yet available, therefore 2007 data are used as a placeholder.

Notes - 2007
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from Oklahoma vital statistics.

Notes - 2006
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

The increase from 73.4% in 2005 to 82.1% in 2006 reflects an increased number of Level III hospitals with NICU facilities in Oklahoma. In addition, an increase in telemedicine consultations and Medicaid referrals is expected to maintain annual indicators above 80%.
Therefore, Objectives for 2008-2012 have been revised to reflect more plausible targets given data from Oklahoma vital statistics.

a. Last Year's Accomplishments
In Oklahoma for 2007, 78.6% (640/814) of infants born weighing less than 1,500 grams were delivered at high-risk facilities. This is a decrease in the rate reported for 2006 (82.1%). In 2000, approximately three-fourths (75.7%) of very low birth weight births occurred at high-risk facilities.

MCH provided data from the Pregnancy Risk Assessment Monitoring System (PRAMS) Project and Vital Records through a variety of means (PRAMSGRAMs, presentations, trainings, etc.) to educate the public, health care providers and policymakers on health issues to include health care access of Oklahoma pregnant women. MCH used this information to make recommendations and facilitate discussion on concerns and changes needed in enhancing the perinatal health care system infrastructure between rural and urban areas as well as primary and tertiary health care providers in the state.

The state's Healthy Mothers Healthy Babies Coalition also used this information in its work to educate families and providers about health issues of women, pregnant women and infants. MCH continued to support the efforts of the coalition through a contractual agreement providing funding for the project's coordinator as well as activities.

Support of the Fetal and Infant Mortality Review (FIMR) projects at the Tulsa Health Department (THD) and the Oklahoma City County Health Department (OCCHD) remained a priority for MCH. The THD FIMR Project continued into its fourth year of conducting full case review and community action activities. The OCCHD entered its third year of conducting case reviews and engaging community partners for action. MCH hired staff to coordinate state level FIMR activities and maternal mortality review.

The Perinatal Advisory Task Force, a collaborative project of the Oklahoma State Department of Health (OSDH) and the Oklahoma Health Care Authority (OHCA), continued to meet every other month. These meetings, co-chaired by the Chief of MCH and the OHCA Director of Child Health, included medical providers, health care agencies and consumers. Members from this task force traveled to the University of Arkansas to observe operation of the Angels Program, a program encompassing practice guidelines and telemedicine to improve perinatal care and link maternal fetal medicine specialists with local physicians to help determine when to transfer patients to achieve optimal outcomes for both mother and infant.

The Perinatal Continuing Education Program (PCEP), University of Oklahoma Health Sciences Center (OUHSC), continued to receive state funding through MCH to provide education and training to medical and nursing staff in rural hospitals. The PCEP provided rural hospital staff with the knowledge and tools to better recognize and manage obstetrical and newborn emergencies. The PCEP was active in 20 hospitals in state fiscal year 2008. Four hundred and seven perinatal health care providers participated in the PCEP, including 19 medical staff members (physicians, certified nurse midwives, physician assistants and emergency personnel) and 388 nursing staff members (registered nurses, licensed practical nurses and respiratory therapists).

The Healthy Start projects in Oklahoma and Tulsa counties, the Children First Program and the Office of Child Abuse Prevention (OCAP) family resource and support projects received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant women and their families and facilitated pregnant women and their families being aware of the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

MCH facilitated the OSDH intra-agency team focused on reducing infant mortality. The Commissioner's Action Team on Reduction of Infant Mortality developed a strategic plan to enhance cross-collaboration among OSDH programs in identifying current activities, gaps in services and needed changes in policy and services to decrease infant morbidity and mortality in Oklahoma. Workgroups were formed to focus on priority areas with potential for positively impacting the infant mortality rate.

MCH provided information for newspaper, television and radio on the effects of prematurity and low birth weight on infants and families in Oklahoma. MCH also partnered with the University of Oklahoma College of Nursing, OHCA, March of Dimes and Healthy Mothers Healthy Babies Coalition to plan and present the annual Prematurity Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided PRAMS data and vital records data through a variety			X	

of means to a wide audience to facilitate understanding of the issue				
2. Supported activities of the state perinatal coalition, Healthy Mothers Healthy Babies			X	
3. Supported the Fetal and Infant Mortality Review projects in Tulsa and Oklahoma counties				X
4. Collaborated with the Oklahoma Health Care Authority (OHCA) to co-chair a task force focused on improving state policy for perinatal care				X
5. Supported the Perinatal Continuing Education Program to provide education and training to hospital-based physicians and nurses				X
6. Provided technical assistance to Healthy Start, Children First and OCAP programs				X
7. Provided leadership for Oklahoma State Department of Health intra-agency team focused on reduction of infant mortality in Oklahoma				X
8. Provided information to public via newspaper, television and radio on the effects of prematurity and low birth weight on infants and families in Oklahoma			X	
9. Partnered with University of Oklahoma College of Nursing, OHCA, March of Dimes and Healthy Mothers Healthy Babies Coalition on annual Prematurity Conference targeting health care providers				X
10.				

b. Current Activities

Support of the FIMR projects at the THD and the OCCHD remains a priority for MCH. Both projects are expanding into the metropolitan statistical areas. Initial meetings have occurred to identify action steps and initial contacts in the targeted counties. Medicaid administrative match funds have been secured to support the projects.

Restructuring of the state's maternal mortality review process was completed. A multi-disciplinary team received training and began reviews in April. The team will meet quarterly with meetings staffed and funded by MCH.

The Perinatal Advisory Task Force recently began exploring the issue of designated levels of nursery care in an effort to assure infants are delivered at the most appropriate facility. This will be one of the focus areas for the next year in looking at how to refine OSDH Board of Health rules and policy around designation to assure alignment with the American Academy of Pediatrics recommendations.

The OHCA established a telemedicine network system for health care providers. MCH is partnering to promote use of this network among perinatal providers.

The Commissioner's Action Team on Reduction of Infant Mortality added a workgroup to specifically address prematurity in Oklahoma. This group will partner with the March of Dimes to promote awareness of the magnitude of this issue as well as interventions to decrease the rate of preterm births and associated morbidity and mortality.

c. Plan for the Coming Year

The OSDH will continue to support the FIMR projects' efforts to expand into the metropolitan statistical areas with funding and technical assistance. Maternal mortality review will continue

and be refined. Findings and recommendations from these multidisciplinary review processes will be used to make systems improvements to enhance positive outcomes for mothers and infants.

MCH will continue to provide support to the Healthy Mothers Healthy Babies Coalition. Technical assistance will continue to the Healthy Start projects in Oklahoma and Tulsa counties, the Children First Program and the OCAP family resource and support programs. A priority focus for interactions will center on identifying ways to address racial disparities seen in infant mortality.

The OSDH has submitted an application for funds to partner with the Oklahoma Healthy Start projects to provide a conference focused on "Developing Our Community and Health Care Workforce to Improve Birth Outcomes". If funding is approved, Oklahoma will partner with Arkansas, Louisiana, New Mexico and Texas in this effort. Sessions will focus on improving birth outcomes by decreasing the preterm birth rate, decreasing the rate of low birth weight births and reducing poor pregnancy outcomes for disadvantaged women.

The OSDH intra-agency team focused on reducing infant mortality has expanded efforts and is engaging state and community-based agencies and organizations. On May 4, 2009 the "Improving Infant Outcomes Forum" was held in Oklahoma City where activities of the Commissioner's Action Team on Reduction of Infant Mortality were shared with partner agencies and other stakeholders. Opportunities were presented for those in attendance to engage in specific workgroup(s) of their choice depending on their specific interest/focus. The OSDH team will continue to meet monthly to assure coordination of the individual workgroups' as their strategic plans are updated to be statewide, collaborative partnership efforts and planned activities are carried out. Plans are to have an annual meeting to update all stakeholders on the status of infant mortality and ongoing activities. Web pages are under construction as well as a toolkit that will be part of a statewide media effort for September, infant mortality month.

The Perinatal Advisory Task Force will move forward with the development of protocols to standardize care for women with high risk perinatal conditions to help assure that prenatal care providers across the state provide the same standard of care in consultation with maternal fetal medicine specialists and transfer care as soon as appropriate to insure the best infant outcome. A focus this year will be developing a standardized, state supported system to identify appropriate levels of care provided in neonatal intensive care units across the state. Work will progress on promoting the telemedicine network to help improve access to appropriate care for pregnant women across the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	83.5	84.8	79.3	80.5	81.7
Annual Indicator	78.1	75.5	74.0	74.5	74.5
Numerator	38758	39085	39943	40915	40915
Denominator	49623	51775	54010	54946	54946
Data Source					OSDH Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	74.7	74.9	75.1	75.3	75.5

Notes - 2008
Source: Health Care Information, OSDH. Data for year 2008 are not yet available. Year 2007 is repeated as an estimate.

Notes - 2007
Source: Health Care Information, OSDH.

Higher future annual performance objectives reflects the expectations of the Soon-To-Be-Sooners Medicaid program which will expand prenatal care available to pregnant women who are non-citizens.

Notes - 2006
Source: Health Care Information, OSDH.

a. Last Year's Accomplishments
In 2007, the most recent year for which data are currently available, 74.5% of all Oklahoma births occurred to women initiating prenatal care (PNC) during the first trimester of pregnancy. This is a slight increase from 74.0% reported in 2006. Generally, the rate for receiving first trimester prenatal care among Oklahoma women has been unchanged in recent years. Data from the Health Care Information, Oklahoma State Department of Health (OSDH) show racial and ethnic variability in receipt of first trimester PNC in 2007: White 76.3%, African American/Black 68.8%, Native American/American Indian 66.6% and Hispanic 63.9%.

Time of initiation of prenatal care continued to be a priority topic of discussion in interactions with the Healthy Mothers Healthy Babies Coalition, Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS). The Perinatal Advisory Task Force, initiated by OHCA and MCH, continued to meet and engage providers and provider organizations in discussions on how to improve utilization and access of services.

Effective April 1, 2008 the OHCA expanded health care benefits to infants who will be born as citizens of Oklahoma regardless of citizenship status of the mother through Soon-To-Be-Sooner (STBS), an expansion of Medicaid benefits under the State Children's Health Insurance Program (SCHIP). This improved access to early prenatal care for many Oklahoma women.

Two PRAMSGRAMs were published: Preconception Care Among Oklahoma Women and African American Perinatal Health Disparities. Both were heavily accessed and used by providers and policymakers. The second PRAMSGRAM data indicated that African American women actually accessed early prenatal care as often as white women; however, they experienced issues making access more difficult.

A workgroup of the OSDH Commissioner's Action Team on Reduction of Infant Mortality continued work on the issue of preconception and interconception care and education in Oklahoma. The workgroup met monthly developing a screening tool for women of reproductive age to increase awareness of preconception health care issues including the importance of early entrance into prenatal care. Work was also accomplished to develop a brochure on preconception health issues and questions developed for focus groups to help assess attitudes toward preconception health and access to health care issues.

As part of the activities of the MCH Comprehensive Program Review conducted with county

health departments and routine site visits to contractors, MCH looked at access issues in communities related to prenatal care. Guidance was provided to health care providers on strategies to educate women on the importance of family planning and receiving early prenatal care. Clinic records were audited to assure women with positive pregnancy tests were counseled on the need to initiate care with a maternity health care provider within 15 days. County health departments and contract providers were expected to keep updated resource lists available to assist in linking clients with maternity providers.

Maternity clinical services continued to be provided through county health departments and contract providers with 4,809 women served during calendar year 2008. These services ranged from providing the initial visit (risk assessment, history and physical) and transitioning care to a local provider to providing care throughout the entire pregnancy up to delivery. Most county health departments and contract clinics reported the ability to initiate care for clients within two weeks of the documented positive pregnancy test or request for services. County health department and contract staff continued to assist women with the completion of Medicaid applications to facilitate the approval process.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborated with the Oklahoma Health Care Authority to facilitate a task force focused on improving state policy for perinatal services				X
2. Disseminated information/data through PRAMSGRAM related to preconception care and health disparities in the state			X	
3. Formalized Preconception/Interconception Care and Education Workgroup with focus on activities to reduce infant mortality				X
4. Provided technical assistance to county health departments and contract providers through MCH comprehensive program reviews and routine site visits				X
5. Provided clinical maternity services as a safety net provider through county health departments and contract providers	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OSDH continues to partner with the OHCA to promote the STBS program implemented April 1, 2008, which provides health care benefits for unborn children of pregnant women who would not otherwise qualify for SoonerCare benefits due to their citizenship status.

The OSDH is working with the OHCA on a project called "No Wrong Door" that will establish an online enrollment process that allows members or potential members of SoonerCare to apply and receive eligibility electronically at county health departments. Once in place, clients will have a Medicaid eligibility determination and, if qualified, a Medicaid identification (ID) number assigned before leaving the clinic. The anticipated start date of this project is early 2010.

MCH is partnering with the OHCA and the Perinatal Continuing Education Program, University of Oklahoma Health Sciences Center to provide leadership for standardizing protocols for perinatal care in Oklahoma.

The Preconception/Interconception Care and Education Workgroup of the Commissioner's Action Team on Reduction of Infant Mortality has completed development of a risk assessment tool to be used during health care encounters with all non-pregnant women and a brochure for men and women highlighting preconception health issues.

A PRAMSGRAM was released regarding prenatal care counseling disparities highlighting the significant disparities in prenatal care content and exploring perceived barriers to standardized care.

c. Plan for the Coming Year

The OSDH will encourage all staff in maternity and family planning (for positive pregnancy tests) to help women apply for Medicaid (SoonerCare or STBS) upon initial contact to improve access to prenatal care for all women as soon as possible.

The Perinatal Advisory Task Force will continue to work toward establishing standardized protocols and promote expansion of the newly established telemedicine network to help women access early and appropriate prenatal care.

The Preconception/Interconception Care and Education Workgroup of the Commissioner's Action Team on Reduction of Infant Mortality will facilitate focus groups to assess attitudes about health care, sources of health care information and perceived barriers to accessing health care. These focus groups will be heavily focused on receiving input from African American females with the information to be used to identify needed changes to health care services and environments in efforts to improve earlier access and more appropriate and routine utilization of services.

The OSDH will continue to work with the OHCA towards the implementation of No Wrong Door. The ability to link with Vital Records data to establish citizenship status will facilitate the eligibility process.

MCH will continue Comprehensive Program Review visits to county health departments and routine site visits to contractors and assess access issues in communities related to prenatal care, especially in communities where MCH funded maternity clinics have closed. Guidance will be provided to health care providers on strategies to educate women on the importance of receiving early prenatal care. Clinic records will continue to be audited to assure women with positive pregnancy tests are counseled on the need to initiate care with a maternity health care provider within 15 days.

With the implementation of STBS, many women are seeking care with private Medicaid providers. This has led to a decreased need for MCH to fund direct maternity clinical services and has allowed a shift in these funds to support enabling, population-based and infrastructure services. The four contractors who have for many years provided maternity clinical services have either discontinue maternity clinical services as other providers in the community have assumed the care with the expansion of Medicaid benefits or are continuing clinical services with Medicaid funds supporting the cost of services. MCH does plans to continue providing gap-filling direct maternity clinical services through the county health department system. County health departments and contract providers no longer having maternity clinics will still provide pregnancy testing and will be expected to keep updated resource lists available to assist in linking clients with maternity providers.

D. State Performance Measures

State Performance Measure 1: *The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	41.5	40.9	50.8	49.8	48
Annual Indicator	51.9	48.8	48.4	48.0	48.0
Numerator	26550	25266	24950	25073	25073
Denominator	51157	51775	51545	52250	52250
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	47.8	47.6	47.4	47.2	47

Notes - 2008
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2007. Data for year 2008 are not available at this time. Year 2007 data repeated as an estimate for 2008

Notes - 2007
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2007.

Despite having exceeded the Annual Performance Objective for 2006, the objectives for 2008-2012 have not been revised for lack of evidence of a significant decrease in the percent of pregnancies which are unintended.

Notes - 2006
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2006.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from PRAMS. Objectives are targeted to a step-wise decline in the unintended pregnancy rate.

a. Last Year's Accomplishments
MCH continued to monitor unintended pregnancy through data from the Centers for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system that provides health information on women who delivered a live birth in Oklahoma. In 2007, the latest PRAMS data available, approximately 48.0% of Oklahoma live births were the result of an unintended pregnancy, with 36.5% mistimed and 11.5% unwanted. This finding is consistent with previous years reporting of the PRAMS data, which has seen the unintended pregnancy rate among live births fluctuate slightly from year-to-year but remain at nearly half of all live births.

The Oklahoma Medicaid Family Planning Waiver implemented in April 2005, continued to provide family planning services to uninsured men and women 19 years of age or older who were United States citizens or qualified aliens, residents of Oklahoma, not eligible for regular Medicaid and who met the income standard (185% of Federal Poverty Level). Services provided included office visits and physical exams related to family planning; birth control information, methods and supplies; laboratory tests including pap smears and screening for sexually transmitted infections; pregnancy tests; tubal ligations for females age 21 and older; and, vasectomies for males age 21 and older. The Oklahoma State Department of Health (OSDH) continued to collaborate with the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) to evaluate and improve services provided through the waiver. The requirement for citizenship verification impacted enrollment with enrollment falling to below 17,000 during the year.

Family planning services were provided through county health departments and contract clinics. Services included medical histories, physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, STD/human immunodeficiency virus (HIV) screening and prevention education, pregnancy testing, immunizations and education on smoking cessation, nutrition and exercise. Services were provided to a total of 78,856 females and males of reproductive age for the period of December 1, 2007 through November 30, 2008.

With numerous advanced practice nurses (APNs) retiring and more looking toward retirement in the next 4-5 years, MCH and Community Health Services (CHS) collaborated on several strategies to retain and hire APNs. An agency budget request to increase salaries was developed based on salary information from national studies as well as Region VI public and private employer compensation schedules and forwarded to the Oklahoma Legislature for funding. The policy of having OSDH approved written orders signed by a physician from which to practice that many APNs viewed as being too restrictive and cited as a barrier to retention and recruitment, was changed. The new policy developed provides for OSDH approved resources (textbooks, national guidelines, on-line sources) and a signed agreement with a physician allowing more flexibility for APNs in their decision-making and practice within the OSDH system.

Federal Title X targeted supplemental funds continued to support the Male Involvement Special Project in Bryan, Choctaw and McCurtain counties. This project focused on increased awareness of family planning and related male and preventive health issues and promoted individual and community health by emphasizing clinical services for males of reproductive age. Outreach to African American and Native American populations occurred using culturally appropriate educational outreach sessions, media campaigns and male-focused clinics. Monthly meetings with community partners and area Turning Point coalitions in the three target counties were used to plan and exchange ideas regarding project development and expansion.

The Preconception/Interconception Care and Education Workgroup of the Commissioner's Action Team on Reduction of Infant Mortality worked to finalize a self-assessment and educational tool to be used by public and private health care providers with females of reproductive age receiving health services.

Staff development opportunities were provided throughout the year based on the MCH annual staff development training needs assessment conducted each spring as well as federal Title V and Title X Family Planning priorities and key issues.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinated with the Oklahoma Health Care Authority and the Oklahoma Department of Human Services to assure effective and efficient provision of Medicaid family planning waiver services				X
2. Provided clinical family planning services through county health departments and contract providers	X			
3. Implemented focused efforts to recruit and retain nurse practitioners				X
4. Supported the Title X Special Project for Male Involvement in 3 rural southeast Oklahoma counties		X		
5. Provided leadership for development of preconception self assessment and educational tool for use with females of reproductive age served by public and private health care providers				X
6. Provided staff development (training) opportunities				X

7.				
8.				
9.				
10.				

b. Current Activities

MCH received supplemental funds and grant funds from federal Title X Family Planning to target racial disparities in Oklahoma and Tulsa counties' African American population. Family planning services have resumed in a predominantly African American neighborhood in Oklahoma City and expanded to high-risk zip codes in Tulsa. Outreach workers are targeting low income, at-risk and uninsured men and women.

The federally funded Title X Family Planning Male Involvement Special Project ended November 30. Lessons learned from the project are being used to facilitate changes in family planning services for males.

The Oklahoma Medicaid Family Planning Waiver entered its' fifth and final year April 1. Enrollment is gradually increasing after the impact of implementation of citizenship verification. Enrollment for May 2009 was 18,743. The OSDH is working with the OHCA and OKDHS to submit a renewal application in September.

The Preconception/Interconception Care and Education Workgroup received approval from the OSDH Institutional Review Board to conduct focus study groups to learn more from women about their perceptions of what leads to unintended pregnancy as well as other health related issues. This information will be used for changes in policy and services.

The legislature did not provide funding for salary increases for APNs given the current state budget deficit. MCH and CHS continue to gain input from APNs regarding ways to retain and recruit for these critical positions.

c. Plan for the Coming Year

PRAMS data and data from linkage of PRAMS, vital records and Medicaid will be used to educate to stakeholders and policy-makers on Oklahoma health issues and trends. This information will also be used to explore needed policy changes and ways health services are provided.

Oklahoma will submit a request to the Centers for Medicare and Medicaid Services (CMS) for a 3-year Medicaid Family Planning Waiver. The waiver will continue to offer services to low-income females and males of reproductive age who would otherwise not be eligible for Medicaid covered services. Oklahoma has been able to document a cost savings of $8 million a quarter with the existing waiver.

Family planning services will be provided through county health departments and contract clinics. Services will include medical histories, physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, STD/HIV screening and prevention education, pregnancy testing, immunizations and education on smoking cessation, nutrition, exercise and healthy weight.

The federally funded Title X special projects focused on outreach, education and provision of family planning clinical services to the African American population will move into its second year in Oklahoma and Tulsa counties. These special projects are supported as a priority from the Region VI Title X Family Planning Office given Oklahoma's rate of unintended pregnancy in the African American population and disparities in infant mortality between the White and African American populations.

MCH and CHS will explore the feasibility of changes in OSDH policy to assist APNs in payment of school loans as another strategy to retain and hire these critical staff. Adjustment of APN salaries will continue to be a priority and a topic of discussion with the new OSDH Commissioner of Health soon after the beginning of the 2010 state fiscal year.

The Preconception/Interconception Care and Education Workgroup will conduct focus groups to gain information from reproductive age females about their perceptions regarding utilization of health services to include use of services to prevent unintended pregnancy. A specific priority within this activity will be to gain information from African American females. The workgroup will expand and actively recruit community partners to assist in efforts to promote the importance of preconception/interconception health care and education. A web page on preconception/interconception care will be finalized and will include information on the positive individual and family outcomes of planning pregnancy.

Numerous staff development opportunities will be provided throughout the year with topics to include unintended pregnancy, adolescent pregnancy prevention and the relationship of drug and alcohol abuse in adolescents to unintended pregnancy. Training will continue to be available to all staff on creative methods for including males in clinic services.

State Performance Measure 3: *The percent of adolescents grades 9-12 smoking tobacco products*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	24.8	24.4	28.2	27.7	23
Annual Indicator	26.5	28.6	28.6	23.2	23.2
Numerator	69200	42781	42970	35197	41369
Denominator	261131	149585	150246	151710	178316
Data Source					YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	22.7	22.4	22.1	21.8	21.5

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006
Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from the Oklahoma YRBS. Objectives are targeted toward a step-wise decline in adolescent smoking rates.

a. Last Year's Accomplishments
Data from the statewide 2007 Oklahoma Youth Risk Behavior Survey (YRBS) reveal that 23.2% of adolescents in grades 9-12 report cigarette smoking in the past 30 days, which is the time period used to define a current smoker. This finding is a slight decrease in the current smoking

rate in this age group reported as 28.6% from the 2005 Oklahoma YRBS. According to national 2007 YRBS data from the Centers for Disease Control and Prevention (CDC), an estimated 20% of high school students are current cigarette smokers.

The percentage of students who had ever tried smoking declined in 2007 from 2005. The 2007 results indicate 54.8% of students had ever tried smoking, compared to 2005 where 62.3% had ever tried smoking. The percentage of students who ever smoked on a daily basis was also down from 2005, 17.8% to 13.3%.

The self-select YRBS was completed for 13 schools during the spring semester of 2008. MCH maintained responsibility for processing and analyzing the data. The individual schools maintained ownership of the data, to be utilized for Title IV activities, grant applications and to direct activities to impact a variety of health outcomes, including tobacco cessation. As requested, MCH provided technical assistance and support to schools to assist them in interpreting data, setting program activities and linking schools with organizations who specialize in tobacco use prevention.

MCH began preparation for the 2009 YRBS statewide random survey. Efforts were coordinated with the Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service, Cherokee Nation and the Oklahoma State Department of Education (OSDE) regarding the Youth Tobacco Survey (YTS) and an independent YRBS survey being completed by the Cherokee Nation.

Development of seven fact sheets using data from the 2007 YRBS statewide random survey as well as YRBS trend data (2003, 2005 and 2007) was started. The fact sheets were to highlight the key risk areas of the survey including tobacco use. The tobacco fact sheet was completed and shared with policymakers, school administrators and key stakeholders as well as placed on the MCH web page for review and use. MCH offered presentations to education leadership groups during the summer of 2008 on the background and benefits of participating in the statewide survey, including how the results could be utilized to incorporate activities to reduce tobacco use among youth.

MCH coordinated efforts with the Tobacco Use Prevention Service to provide training at the Oklahoma Health Care Authority and Oklahoma State Department of Health (MCH) facilitated Child Health Advisory Task Force in June 2008. Training included education about data, the impact of tobacco use on health and tips for providers on how to educate patients about cessation (focused on the 5 A's).
MCH worked with Tobacco Use Prevention Service to discuss strategies on how to make the Tobacco Hotline more accessible and useful to Oklahoma youth. Currently, Oklahoma youth cannot receive nicotine replacement therapy without parental consent. A request for a legal opinion was routed to the OSDH Office of General Counsel to determine the feasibility of reversing the policy.

State dollars continued to fund 13 rural district school health nurses through a contractual agreement with the OSDE. Tobacco use prevention was a priority within each school health nurse's annual work plan. The School Health Coordinator in MCH provided technical support and assistance.

Collaboration continued with the Tobacco Use Prevention Service and OSDH Dental Health Service promoting prevention activities and efforts across the state. Strategies to reduce tobacco use included support for community-based initiatives, classroom programs and youth cessation programs. The focus for these activities continued to be on elementary and middle school students. In addition, information was provided to all schools in the state to encourage development and adoption of policy that would not allow smoking on school grounds 24-hours a day seven days a week.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered the Youth Risk Behavior Survey (YRBS) for local schools requesting				X
2. Began preparation for 2009 statewide administration of YRBS				X
3. Distributed YRBS data to wide audience to educate on youth tobacco use			X	
4. Collaborated with the Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service and Dental Health Service on youth prevention activities and efforts across the state			X	
5. Provided education to members of the Child Health Advisory Task Force to impact provider services				X
6. Supported rural district school health nurses; tobacco cessation a priority focus area			X	
7.				
8.				
9.				
10.				

b. Current Activities

Meetings between MCH, Cherokee Nation and Tobacco Use Prevention Service were held in October 2008 for the purpose of coordinating efforts for the administration of the YRBS and YTS. The administration of the statewide random YRBS was completed in June 2009. Forty-one of the 50 selected schools participated in the survey this year.

MCH continues to provide technical support and resources to the state funded school nurses in rural Oklahoma. The school nurses provided one-on-one, in-class and group education on tobacco prevention and cessation. MCH provides technical assistance for the development of the school nurses' annual plans, which outline specific goals, objectives and activities to be completed within the school year. Each annual plan submitted by the nurses includes a component addressing tobacco use prevention and cessation.

MCH provides tobacco prevention education to policymakers and other stakeholders. Proposed legislation to limit access to tobacco products by youth and to reduce exposure to secondhand smoke in public places failed in the 2009 legislative session.

c. Plan for the Coming Year

It is anticipated that YRBS state data from the CDC will be received by October 2009. Tobacco Use Prevention will also receive state YTS data. Collaboration will occur in the preparation of fact sheets, including trend data, and education to policymakers and stakeholders about the importance of reducing youth access to tobacco.

MCH will continue to seek opportunities to present YRBS data and information on the background and benefits of participating in the statewide survey to education leadership groups, public health entities and parent organizations, such as the Parent Teacher Association (PTA). The presentations will be made during the fall of 2009, upon the receipt of the YRBS data and subsequent completion of the fact sheets.

A contractual agreement with the OSDE to fund school nurses in rural areas of Oklahoma will

continue. MCH will work directly with these school nurses to provide technical assistance and support for the development of annual work plans which include goals and objectives related to tobacco use prevention and tobacco use cessation programs at all grade levels.

MCH will continue to follow annual legislation, as it is introduced, to limit access to tobacco products by youth as well as legislation that might diminish the impact of current laws to reduce youth access to tobacco products or exposure to second hand smoke.

State Performance Measure 4: *The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	130	134	144	160	168
Annual Indicator	120	142	152	138	62
Numerator					
Denominator					
Data Source					CSHCN Program, OK Dept of Human Services
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	60

Notes - 2008
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Number of respite vouchers provided by CSHCN has decreased because of the availability of funding from other sources. This is an unduplicated count, however CSHCN provides 2 vouchers per year to most families.

Notes - 2007
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Notes - 2006
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

a. Last Year's Accomplishments
The Oklahoma Areawide Services Information System (OASIS) remained the central processing agency for respite care applications in the state. The OASIS determined eligibility and made referrals to the appropriate funding sources: CSHCN, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) or the OKDHS Children and Family Services Division (CFSD) which
administers programs for children in foster care. The OASIS received 8,760 contacts related to the Respite Voucher Program. Of those, 440 were requests for respite care. The OASIS determined each family's eligibility then routed the application to the proper funding source. CSHCN issued vouchers for 62 families, the DDSD issued 118 vouchers and the CFSD issued 36 vouchers.

The number of vouchers issued through CSHCN declined by 50% in 2008. There were two main

reasons for this. The first was a change over the past year in the method of referrals for respite services. In the past, almost all referrals went through the OASIS who determined eligibility for respite services and issued the vouchers. Beginning this year, people could use the Joint Oklahoma Information Network (JOIN)/211 to request respite services. JOIN/211 did not provide CSHCN with any data therefore there is no way of knowing if families were referred to the OASIS or were sent directly to the Oklahoma Respite Resource Network to obtain services. The second reason CSHCN issued fewer vouchers was due to a policy change limiting the number of times the same family could receive a voucher during the year. This was done as a cost-saving measure to insure all families needing respite services received at least one voucher in a 12-month time period.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided for respite services		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN provides funding for respite care at JD McCarty Center. Children can stay at the center for a total of 7 days one time per year. Children do not attend school or receive therapy while there, but they do participate in recreational activities.

Two programs already underway through the Oklahoma Respite Resource Network are the Respite Provider Registry that provides a listing of agency respite providers and the Respite Voucher Program that provides funding assistance for the purchase of respite services. Requests and applications for services are made to the OASIS. The OASIS determines eligibility and makes referrals to the appropriate OKDHS funding: Aging Services Division (ASD), DDSD, Temporary Assistance for Needy Families (TANF) Unit or CSHCN. Because there is more funding available through other programs, CSHCN has not paid for as many respite vouchers over the past year.

CSHCN presented at the Governor's Conference on Disabilities this year. Several family members expressed their appreciation of the availability of the Respite Voucher Program. Concern was expressed that some families do not have family members who are comfortable being caregivers. The OASIS has a list of people who are willing to provide respite and this information was shared with the attendees.

c. Plan for the Coming Year

The Oklahoma Respite Resource Network updates the Respite Provider Registry as providers stop services and others begin. CSHCN will continue working with the Oklahoma Respite Resource Network to identify additional sources of funding to expand the respite services.

State Performance Measure 6: *The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			21	21	18
Annual Indicator		14	14	15	15
Numerator					
Denominator					
Data Source					MCH Assessment, OSDH
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	18	18	18	18

Notes - 2008
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Notes - 2007
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A. Future annual performance objectives have been adjusted to more realistically reflect MCH data capacity.

Notes - 2006
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

a. Last Year's Accomplishments
Linking Medicaid data with vital records was initiated. A position jointly funded by the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, and the Oklahoma State Department of Health (OSDH) had responsibility for linking and analyzing the linked data between Medicaid, Oklahoma vital records and other OSDH databases. Medicaid data was successfully linked to Oklahoma births for 2005 and 2006 and initially reviewed. With well over one-half of all live births covered by SoonerCare (Medicaid), preliminary data provided both agencies insights into the characteristics of reproductive age females utilizing publicly assisted medical services for prenatal care and delivery.

Matching of data also enhanced other MCH-related services. The data was used to confirm the number of children captured in the Oklahoma State Immunization Information System (OSIIS) who were Medicaid eligible. This was used to set the Medicaid reimbursement rate to the OSDH for immunization services provided to Medicaid children. The OHCA began utilizing the matched data to validate information previously estimated. The matched data was also used in developing responses to the hypotheses that were set for the SoonerPlan evaluation, Oklahoma's family planning Medicaid waiver program. PRAMS data were also checked against the matched data to validate mothers' responses to having prenatal care and delivery services paid by SoonerCare.

Enhancing the need for linking data was accomplished through building awareness of its benefits in the OHCA/OSDH Perinatal Advisory Task Force and the Child Health Advisory Task Force. That awareness improved the support for creating and sustaining the interagency data linkage project.

Work on joining datasets began within another unit of the agency with the intended purpose of enabling clients to enroll in public assistance programs external to the OSDH (No Wrong Door, see NPM#18).

The Public Health Oklahoma Client Information System (PHOCIS) linked information for all direct services provided by OSDH, including WIC, Maternity, Child Health, Family Planning, Immunization and other MCH-related services. Once Medicaid information is linked with vital records, MCH will begin the process of joining other datasets into the linked file.

Birth and infant death certificates continued to be routinely linked within the OSDH Office of Vital Records. The success of linking records did not improve significantly until the implementation of the electronic birth certificate. The current match rate is typically 98% or higher.

Oklahoma continued to maintain one of the more comprehensive active birth defects surveillance systems in the country. The primary complication continued to be access to this confidential dataset.

The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) Project completed its 20th year within MCH. The project continued to serve as a primary source of preconception, prenatal and postpartum information for mothers and their pregnancies. The project not only served MCH and the OSDH, but external partners and policymakers who rely upon this unbiased source of information. In addition to providing special analyses on demand, printed reports and presentations were prepared throughout the year. These included topics such as maternal depression, preconception and African American disparities. In addition, The Oklahoma Toddler Survey (TOTS) information was integrated with the PRAMS data to provide a presentation on repeat unintended pregnancies. TOTS also prepared two reports in 2008: unintentional childhood injuries and child care for two-year olds.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Linked Vital Statistics data and Medicaid data for analysis projects				X
2. Disseminated data on selected MCH topics to policymakers, key stakeholders and interested parties			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data used to assess this measure are derived from the reporting on Health Systems Capacity Indicator (HSCI) #09A. State data capacity defined under HSCI #09A is the principal focus of the Maternal and Child Health Bureau (MCHB) funded Oklahoma State Systems Development Initiative (SSDI) Grant. The SSDI Grant continues to provide critical infrastructure support for expanding and enhancing the Title V Program's ability to gather and analyze data.

The PRAMS continues to produce the PRAMSGRAM publication, special reports and data analyses upon request. These results represent current subjects of importance to the MCH community. In addition, the PRAMS-TOTS linked datasets provide further information about early child outcomes and healthcare issues impacting the health of young children.

Discussion has been initiated between the Chief of MCH and the Chief of Screening and Special

Services regarding linkages with the Oklahoma Birth Defects Registry.

The OSDH Health Care Information System (HCI) is developing an internal data mining system to link databases managed by HCI, including hospital discharge data and all vital records. While it does not permit a matching capability with the linked Medicaid data in MCH, it will potentially provide more complete analyses of the hospital discharge database.

c. Plan for the Coming Year

Efforts are underway to make more of the data available to providers and the general public. Outlets for the use of linked data will be maintained and expanded to enhance the awareness of the health status and need of the MCH populations.

Future steps for data linkage will be explored (e.g. linking matched Medicaid data to the birth defects registry; Public Health Oklahoma Client Information System (PHOCIS), the OSDH's database that includes clients served in Maternity, Child Health, Family Planning, Immunization, WIC and Children First, the nurse-family partnership program for the state).

Analyses of the Medicaid linked data will be included in the Title V MCH Block Grant five-year needs assessment due in July 2010.

The joint OHCA/OSDH Perinatal and Child Health task forces will continue to be utilized for input and advice about detailed analyses of linked data and other data resources. These task forces are composed of individuals representing academia, professional organizations, providers, advocates and families. Their responsibility includes investigating issues surrounding the delivery of Medicaid services, including barriers, scope and other concerns. Because Medicaid covers approximately 60% of all deliveries in Oklahoma, their focus will be useful in providing a perspective external from the MCH for analyzing these large databases.

More analyses of PRAMS and TOTS data are planned, including the use of the combined databases to assess longitudinal issues impacting both early child health and maternal health.

State Performance Measure 7: *The percent of Medicaid eligible children with special health care needs who report receiving routine dental care.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			20	39.4	42
Annual Indicator			38.3	41.5	43.8
Numerator			10908	10758	10110
Denominator			28496	25921	23073
Data Source					CSHCN program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42.5	43	43.5	44	44.5

Notes - 2008

Source: CSHCN program, OKDHS.

Notes - 2007

Source: CSHCN program, OKDHS. Medicaid claims data, OHCA.

Notes - 2006
Source: CSHCN program, OKDHS. Medicaid claims data, OHCA.

Objectives for 2007-2011 have been revised to reflect more plausible targets given recent data from CSHCN Program. Targets reflect step-wise upward trend in the percent of CSHCN receiving dental care.

a. Last Year's Accomplishments
The Oklahoma Health Care Authority (OHCA) reported an average of 10,110 monthly encounters for routine dental services for Medicaid-eligible children who were classified as disabled or who were in the custody of the state. This was a decrease of approximately 648 encounters per month from last year. Further analysis of the data found that the main reason for this decrease was the number of children in foster care who receive routine dental services decreased by 44%.

The Oklahoma Areawide Services Information System (OASIS) Family Outreach Coordinator continued to co-chair the Children's Oral Health Coalition that worked to improve the access to and quality of dental care for all children in Oklahoma, including children with special needs. The work of the coalition, in conjunction with the Medical Home Project in Oklahoma, helped provide dental homes for children with special health care needs, in addition to a medical home. The coalition produced a toolkit intended to make dental visits less stressful for families and professionals. The toolkit was made available to the public on the Oklahoma Association of Community Action Agencies' (www.okcaa.org.) site. The toolkit has helpful hints for families and professionals on how to deal with specific problems (such as seizures and touch-related aversions) that may occur during a dental appointment.

In 2007, the Oklahoma Dental Association along with twelve other organizations, including the Oklahoma Department of Human Services (OKDHS), Oklahoma State Department of Health (OSDH), Oklahoma Health Care Authority (OHCA), Oklahoma Commission on Children and Youth (OCCY) and the University Of Oklahoma College Of Dentistry, asked Governor Henry to form the Governor's Task Force on Children and Oral Health. The purpose of the task force was to study the existing state, federal and private sector programs that address the health of children, youth and families to look for duplication of effort and resources. The planned task force was to determine ways to infuse oral health education, dental care and dental disease prevention into existing programs. The task force was also to specifically address programs for children and youth as well as those with special health care needs, make recommendations regarding the need for new programs and develop a State Oral Health Plan. The OASIS Family Outreach Coordinator (who co-chairs the Children's Oral Health Coalition) and the OSDH Chief of Dental Health Services were members of this task force. The task force had two meetings in 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated with the Children's Oral Health Coalition (COHC) to help complete their toolkit				X
2. Supported family representation on the Governor's Task Force on Children and Oral Health				X
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

The AAPD (American Academy of Pediatric Dentists) and Head Start are partnering at the national, regional, state and local levels to develop a national network of dentists to link children in Head Start with dental homes. A dental home means that each child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. Titled "Head Start Dental Home Initiative", a state was chosen from each of the Health and Human Services 10 regions to be a pilot state. The initiative is expanding in 2009 and Oklahoma is the next Region VI state to begin the initiative. As part of the initiative, dental professionals along with Head Start and community leaders from around Oklahoma are being brought together. They will identify barriers that prevent children in Head Start from finding and keeping dental homes and then develop and implement strategies to overcome those barriers. The network of dental professionals developed by the initiative will not only provide quality dental homes, but also train dentists and Head Start staff on optimal oral health care practices and help in meeting the full range of oral health needs children in Head Start have.

The Governor's Task Force on Children and Oral Health continues to meet. Data are being collected regarding the incidence and accessibility of oral health care in the state. A report with recommendations is expected by August 2009.

c. Plan for the Coming Year

A two-day Mission of Mercy (MOM) will be held in Tulsa in February 2010. This event will bring together oral health professionals from around the region to offer dental services free of charge to help anyone who attends. Volunteers will help organize the hundreds of people who are expected to come. Pediatric dentists will be on hand to help children, including CSHCN, with needed oral health services. Similar events in Kansas and Arkansas provided much needed care to hundreds of children and their parents.

CSHCN will continue working with the subcommittees of the Oral Health Coalition to complete the remainder of their action plan. The work of one subcommittee is to improve the access of families to comprehensive health and related services through a medical home and continuous screening. This subcommittee will support legislation that would require dental check-ups before a child can enroll in school; implement clinical training in serving children and youth with special needs with continuing education unit (CEU) credit for dentists, doctors and dental staff; and, increase Medicaid rates or find other incentives to increase the number of SoonerCare providers.

Another subcommittee will focus on ensuring adequate public and private financing of needed services. The subcommittee will advocate for Medicaid and private insurance carriers to change their present policies to put more of an emphasis on prevention. Efforts will also be made to recruit more providers for children and youth with special needs through organizing more free dental clinics and the creation of private scholarships and loan forgiveness programs.

Another subcommittee of the Oral Health Coalition will look at how to organize community services so that families can easily access them and advocate for the simplification of SoonerCare processes and language so poor families will find it easier to get care for their children. Work will be done to develop a database and referral system for dentists who treat children and youth with special needs. The subcommittee will also develop training for dentists to learn effective care coordination.

State Performance Measure 8: *The percent of adolescents grades 9-12 not using alcohol during the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			60.7	61.9	63.1
Annual Indicator		59.5	59.5	56.9	56.9
Numerator		89003	89396	86323	101462
Denominator		149585	150246	151710	178316
Data Source					YRBS & OK State Dept of Education
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.4	65.7	66.4	67.1	67.8

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006
Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

a. Last Year's Accomplishments
The statewide Oklahoma Youth Risk Behavior Survey (YRBS) collects data from students in grades 9-12 to track this measure. Data from the 2007 YRBS showed that 43.1% of Oklahoma adolescents had used alcohol in the 30 days prior to the administration of the survey. A higher percentage of male adolescents (46.2%) reported alcohol use during the last 30 days compared to females (40.2%). The most recent national data, 2007, shows 55.3% of U.S. students grade 9-12 reported no alcohol use in the previous 30 days.

The percentage of students in Oklahoma who had their first drink of alcohol (other than a few sips) before thirteen years of age decreased from 25.2% in 2005 to 23.3 percent in 2007. Females had a much lower percentage at 19.2% than males at 27.2%. There was a increase in the percentage of students who had five or more drinks of alcohol in a row (within a couple of hours) one or more times in past thirty days from 26.6% in 2005 to 27.9% in 2007.

Individual YRBS key area fact sheets illustrating 2003-2007 trend data and comparison of state data to national data were created. The Alcohol Use YRBS Fact Sheet was disseminated to state partners, schools, community groups and others.

The MCH Adolescent Health Coordinator, Safe Kids Oklahoma Coordinator and staff from the OSDH Injury Prevention Service, Oklahoma Department of Mental Health and Substance Abuse Services and Oklahoma Highway Safety Office began more formal planning to facilitate recommendations for action and strategies over the coming year.

MCH worked with Injury Prevention Service to revive Teen Driving Roundtable by expanding the committee, inviting new members and scheduling meetings to present committee goals and activities. Quarterly meetings between MCH and Injury Prevention Service assisted in the

development and implementation of these activities.

The MCH Adolescent Health Coordinator continued to serve on the Governor's Task Force on Prevention of Underage Drinking. Oklahoma was chosen as one of eleven states by the Substance Abuse and Mental Health Services Administration (SAMHSA) to create a video with a prevention focus to be completed by spring 2009. Funding and technical expertise for creation of the video is to be provided by SAMHSA. In addition, the Oklahoma Department of Mental Health and Substance Abuse Services had discussions with the Oklahoma Publishing Company with regard to a possible underage drinking prevention campaign.

Since Governor Henry signed The Prevention of Youth Access to Alcohol Bill on May 25, 2006, social host ordinances have passed in 47 communities across Oklahoma. With help from grassroots efforts such as Turning Point, city officials gained understanding and knowledge of how this ordinance can assist with preventing underage drinking parties by holding the "host" of the party liable for allowing underage drinking to occur on their property.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnered with the Safe Kids Oklahoma, Oklahoma State Department of Health Injury Prevention Service, Oklahoma Highway Safety Office and Oklahoma Department of Mental Health and Substance Abuse Services for the development of strategies to reduce ado				X
2. Revived the Teen Driving Roundtable				X
3. Participated in the Governor’s Task Force on Prevention of Underage Drinking				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma Institute for Child Advocacy (OICA) Fall Forum was held in October 2008. One of the key issues to come out of the forum was to request the legislature in the upcoming session to appropriately classify flavored alcoholic beverages (Alco-Pops) as distilled beverages, as currently defined in Oklahoma law, thereby requiring such beverages to be sold only in liquor stores. The Oklahoma Attorney General's Office began investigating and exploring the possibility of the reclassification of Alco-Pops, alcoholic beverages that have some resemblance and taste of soda pop, from a beer tax classification to a distilled spirits classification. This change would increase the tax on these products and prevent them from being sold in certain areas such as convenience or grocery stores, which would have great impact on the accessibility to youth.

The fourth statewide YRBS was completed in June 2009. Oklahoma is anticipating that the data will be able to be weighted given the participation rates for the 2009 YRBS. If it is, Oklahoma will have weighted data for years 2003, 2005, 2007 and 2009.

MCH met with the Oklahoma Highway Safety Office's 2M2L (Too Much to Lose) underage drinking prevention program to begin discussions on how MCH might collaborate and support

2M2L.

c. Plan for the Coming Year
The OSDH will update the Alcohol Use YRBS Fact Sheet to include the 2009 YRBS data. The fact sheet will be shared with school leaders, county health departments, local and statewide media outlets, legislators, Turning Point and community coalitions and other state partners who invest resources aimed at reducing underage drinking.

The Adolescent Health Coordinator will continue to provide representation on the Governor's Task Force on Underage Drinking. The task force will continue to promote legislation directed toward decreasing alcohol accessibility to underage youth. Efforts will also include assuring consistent information and educational resources on negative health outcomes related to underage drinking are provided for community outreach, school health efforts and programs providing services that have an adolescent focused component.

The Adolescent Health Coordinator will partner with the Oklahoma Highway Safety Office's 2M2L underage drinking prevention program, providing them with technical assistance and support for successful 2M2L summer camps. Levels of support include participating in planning of activities, providing presentations and promoting the camp to potential youth recipients.

MCH will explore through existing partnerships with Injury Prevention Service, Oklahoma Turning Point, Safe Kids Oklahoma, Oklahoma Highway Safety Office, Oklahoma State Department of Education and Oklahoma Department of Mental Health and Substance Abuse Services further efforts to support state and local initiatives to prevent and reduce underage drinking.

State Performance Measure 10: *The percent of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					29.6
Annual Indicator		31.1	31.1	29.9	29.9
Numerator		46521	46727	45361	53316
Denominator		149585	150246	151710	178316
Data Source					YRBS & OK State Department of Education
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29.3	29	28.7	28.4	28.1

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006
Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

a. Last Year's Accomplishments
According to the latest Youth Risk Behavior Survey (YRBS) data there have been no significant changes in the percent of adolescents at risk for overweight in the past 3 years. In 2007, 29.9% of adolescents in grades 9-12 were overweight or obese compared to approximately 31.1% in 2006. In 2007, the percentage of female adolescents who were overweight or obese was 26.6% compared to 32.9% of male adolescents who were overweight or obese.

During the 2008 legislative session, an unfunded mandate, Senate Bill (SB) 519 was passed, authorizing the Oklahoma State Department of Health (OSDH) to pilot test physical fitness assessment software in 15 elementary schools for students in grades 3-5. MCH partnered with the OSDH State Physical Activity and Nutrition Director and OSDH Information Technology to begin planning of the project and develop written specifications to purchase existing fitness testing software for use by selected pilot schools across the state.

MCH collaborated with the Fit Kids Coalition (FKC), Oklahoma State Department of Education (OSDE) and Action for Healthy Oklahoma Kids (AHOK) to provide statewide trainings to school personnel and partners on how to use the Strong and Healthy Oklahoma Schools Manual. Additionally, MCH provided technical assistance and support to schools on the use of the Centers for Disease Control and Prevention (CDC) School Health Index to guide them in the development of their needs assessment and program activities in the areas of nutrition and physical activity.

The passage of SB1612 created a mini-grant program with the OSDH to assist out-of-school-time programs to incorporate elements to reduce childhood obesity. MCH provided resources and technical assistance to schools and organizations to assist in the implementation of this bill. Additionally, MCH partnered with the Oklahoma Institute for Child Advocacy (OICA), FKC, OSDE and others to introduce legislation requiring two semesters of health education in grades 6-8.

MCH continued to provide input on nutrition and physical activity for children and adolescents through expanded support of the CDC's Coordinated School Health Program model to the Governor's Call To Action Team through the OSDH Commissioner's Call to Action Team on Nutrition and Physical Activity. The Commissioner's Action Team met monthly to develop and refine the agency's strategic plan that integrates into the Governor's plan.

Financial and technical assistance continued to be provided to the Schools for Healthy Lifestyles (SHL) Program. The program included 40 schools in 11 counties including the metropolitan area. SHL continued to focus on nutrition and physical activity for two of the four components of the program.

MCH staff completed the self-select Youth Risk Behavior Survey (YRBS) for 13 schools during the 2008 spring semester. MCH maintained responsibility for processing and analyzing the data. The individual schools maintained ownership of their data that was utilized for Title IV activities, grant applications and assisting the schools in directing activities impacting a variety of health outcomes including physical activity and nutrition. As requested, MCH provided technical assistance and support to schools to assist them in interpreting data and setting program activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Partnered with the Oklahoma State Department of Health (OSDH) State Physical Activity and Nutrition Director and OSDH Information Technology to plan implementation of the fitness assessment software pilot				X
2. Partnered with Fit Kids Coalition, Oklahoma State Department of Education and Action for Healthy Oklahoma Kids to provide training to school personnel and partners on how to use the Strong and Healthy Oklahoma Schools Manual				X
3. Provided technical assistance and support to schools on use of the School Health Index				X
4. Provided resources and technical assistance to schools and organizations to assist in the implementation of new mini-grant program for after-school programs				X
5. Participated on the OSDH Action Team on Nutrition and Physical Activity				X
6. Supported activities of the Schools for Healthy Lifestyles Program			X	
7. Administered the Youth Risk Behavior Survey (YRBS) for local schools requesting				X
8.				
9.				
10.				

b. Current Activities

The 2009 statewide random YRBS was completed this spring. If weighted data is received, Oklahoma will have weighted data for 2003, 2005, 2007 and 2009 to do analyses and look at trends.

Final steps are being accomplished to make the needed purchase to conduct the pilot with the elementary schools. The pilot is to provide information on the ease of schools entering data from individual student fitness testing into a local database and then data being moved into a centralized database at the OSDH. If processes and procedures can be developed, the plan is to expand gradually to statewide and have de-identified data for analyses that will provide further information on the health status of Oklahoma's children.

MCH partnered with the AHOK in the development of the "Game-On" activities. "Game-On" activities encourage children to reduce television and computer screen time and are being presented to students in Oklahoma City and Edmond schools.

MCH provides technical assistance to school nurses and encourages schools to move toward the CDC Coordinated School Health Program model. MCH works with schools statewide to promote the use of the CDC's School Health Index self-assessment tool including the physical activity and nutrition modules. Four School Health Index trainings have been provided across the state with multiple school districts at each of the trainings.

c. Plan for the Coming Year

Active participation will continue on the Commissioner's Call To Action Team on Nutrition and Physical Activity. Input on nutrition and physical activity for children and adolescents will be provided for modification of the OSDH plan as well as the Governor's plan as needed.

MCH will develop fact sheets from the data gained from the 2009 YRBS statewide random survey. Fact sheets will be distributed to policy makers, legislators, school personnel and community partners. Additionally, presentations will be offered at state conferences, school

sponsored events and other educational venues as they are identified.

As requested, MCH will work with local school districts to facilitate the self-select YRBS survey. MCH will process and analyze the data and return it to the schools for their own personal use.

Partnerships will continue with OSDH Community Health Services, Chronic Disease Service, FKC and AHOK to provide training to school staff on conducting the School Health Index in their schools. MCH will continue to work with schools to adopt the CDC Coordinated School Health Program model.

The fitness assessment software pilot in 15 elementary schools, to be selected from across the state, is still being planned for implementation this fall. MCH will work with the identified schools to assure understanding of the pilot and how data provided to a centralized database will be maintained and used.

Contracts supporting the Schools for Healthy Lifestyles Program and the Oklahoma Afterschool Network will continue. Schools for Healthy Lifestyles will work within school programs for students and parents on nutrition education and physical activity programs throughout the state. MCH will work with the contractor on how to expand the number of participating schools. The Oklahoma Afterschool Network will work with afterschool and out of school time programs providing nutrition education and physical activity programs to all school age children as well as other educational programs and activities to promote skills in making healthy life choices.

State Performance Measure 11: *The percentage of full-term infants who are put to sleep on their backs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator			59.7	60.3	60.3
Numerator			27192	28147	28147
Denominator			45575	46659	46659
Data Source					Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	61	62	63	64	65

Notes - 2008
Source: 2008 PRAMS data not yet available, therefore 2007 used as a proxy.

Notes - 2007
Source: 2007 Pregnancy Risk Assessment Monitoring System.

Notes - 2006
Source: 2006 Pregnancy Risk Assessment Monitoring System.

a. Last Year's Accomplishments
This is a new state performance measure for 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This is a new state performance measure.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

See IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES, B. State Priorities

MCH is developing, in collaboration with the Perinatal Continuing Education Program, University of Oklahoma Health Sciences Center, a model hospital infant safe sleep policy and online education course for nurses. The online course is to be available on the Training Finder Real-Time Affiliate Integrated Network (TRAIN). Continuing education credit and a certificate of completion will be available. Letters signed by the new Commissioner of Health will be mailed in July to nurses working in hospitals and birthing facitilities informing them of the course.

The Safe Sleep Workgroup formed as a subgroup of the Commissioner's Action Team on Reduction of Infant Mortality meets monthly. The workgroup has drafted four culturally and linguistically appropriate brochures (African American, Native American, Hispanic and White) that include the same consistent safe sleep message. The workgroup is also designing a web page that will include safe sleep information to include frequently asked questions and additional resources. The safe sleep information will be available for download and use by community partners statewide.

c. Plan for the Coming Year

A model safe sleep policy will be finalized for use by hospitals and birthing facilities that do not have a policy or would like to update their existing policy. The model policy will be shared with all hospitals and birthing facilities and also be placed on the OSDH website.

The infant safe sleep education tool will be made available to other groups that have a significant impact on infant safety and parent education such as child birth educators, child care providers, Children First nurses, community-based child abuse prevention programs and Healthy Start projects.

MCH will explore through input gained during the activities for the Title V MCH Block Grant Five Year Needs Assessment what other strategies might be used to positively impact this measure.

The Safe Sleep Workgroup will expand its membership to include state and community-based partners and refine its strategic plan. Information for the web page focused on infant safe sleep will be finalized as well as information for inclusion in a toolkit focused on reduction of infant mortality.

PRAMS data will continue to be used to monitor the effectiveness of the infant safe sleep

activities. Co-sleeping will be measured in the newest version of PRAMS for infants born in 2009. This data will be available in late 2010.

E. Health Status Indicators

Introduction

See Forms 20 and 21.

Title V designated health status indicators are reviewed regularly as an integral assessment of program monitoring throughout each year. These indicators are a limited representation of the issues that must be tracked routinely to learn of important changes in health status that may be the result of system changes, including health care access, changes in the population or socio-economic shifts of sub-populations. These changes are dynamic and MCH receives relatively rapid feedback from local providers when significant changes impact the MCH health care structure. Moreover, MCH encourages local communities and local public health providers to monitor these same issues to better address changing needs and to assist the Title V administration staff in adjusting programs and funding as needs indicate.

Some health status indicators are not recognized as being strong indicators for Oklahoma MCH programs (e.g. TANF). Others, such as low birth weight, mortality and morbidity due to unintentional injury, provision of demographic information related to live births to women, and deaths to infants and children are used in planning and evaluation of services and are linked with national and state performance measures and related activities. Depending on the degree of changes in health status indicators, further exploration is conducted to identify causative factors leading to the change and potential interventions to impact.

/2010/ No Change //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	8.0	8.0	8.4	8.2	8.3
Numerator	4097	4143	4509	4481	4456
Denominator	51115	51746	53985	54898	53693
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Notes - 2007

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Notes - 2006

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Narrative:
The low birth rate for all live births was unchanged from 2004 to 2005 at 8.0 percent. In the main, the percent of Oklahoma births born weighing less than 2,500 grams has shown little variation over the last five years.
/2009/ The low birth rate for all live births rose slightly from 2005 to 2006 from 8.0 percent to 8.4 percent. In the main, the percent of Oklahoma births born weighing less than 2,500 grams has shown little variation over the last five years. //2009//
/2010/ The low birth rate for all live births decreased slightly from 2006 to 2007 from 8.4 percent to 8.2 percent.

See NPMs #8, #15, #17 and #18 as well as SPM #1. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.6	6.4	6.8	6.6	6.6
Numerator	3271	3221	3587	3533	3533
Denominator	49692	50190	52451	53354	53354
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Health Care Information, OSDH. 2007 data used as a provisional estimate.

Notes - 2007
Source: Health Care Information, OSDH.

Notes - 2006
Source: Health Care Information, OSDH.

Narrative:
The percentage of singleton births declined only slightly from 6.6% in 2004 to 6.4 in 2005, a relative decrease of 3%.
/2009/ The percentage of singleton births increased somewhat from 6.4% in 2005 to 6.8 in 2006, a relative increase of 6.3%. //2009//
/2010/ The percentage of live singleton births weighing less than 2,500 grams decreased somewhat from 6.8% in 2006 to 6.6% in 2007.

See NPMs #8, #15, #17 and #18 as well as SPM #1. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.3	1.4	1.6	1.5	1.4
Numerator	649	743	866	798	760
Denominator	51115	51746	53985	54898	53693
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Health Care Information, OSDH.

Notes - 2007
Source: Health Care Information, OSDH.

Notes - 2006
Source: Health Care Information, OSDH.

Narrative:
The percent of all births that are born weighing less than 1,500 grams increased from 1.3% in 2004 to 1.4% in 2005. This continues a run up in the percentage of all live births delivered weighing less than 1,500 grams, and it represents an absolute increase from 649 very low weight births in 2004 to 743 in 2005. The most recent low occurred in 2003 (1.2%).
/2009/ The percent of all births that are born weighing less than 1,500 grams increased from 1.4% in 2005 to 1.6% in 2006. This continues the upward trend of births less than 1,500 grams, and it represents an absolute increase from 743 very low weight births in 2005 to 866 in 2006. //2009//
/2010/ The percent of all live births that are born weighing less than 1,500 grams decreased from 1.6% in 2006 to 1.5% in 2007.

See NPMs #8, #15, #17 and #18 as well as SPM #1. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.0	1.2	1.3	1.1	1.1
Numerator	519	585	664	603	603
Denominator	49692	50190	52451	53354	53354
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Health Care Information, OSDH.

Notes - 2007
Source: Health Care Information, OSDH.

Notes - 2006
Source: Health Care Information, OSDH.

Narrative:
Among singleton live births, the percent of births born at very low birth weight rose from 1.0% in 2004 to 1.2% in 2005.
/2009/ Among singleton live births, the percent of births born at very low birth weight rose from 1.2% in 2005 to 1.3% in 2006. //2009//
/2010/ Among singleton live births, the percent of births born at very low birth weight dropped from 1.3% in 2006 to 1.1% in 2007.

See NPMs #8, #15, #17 and #18 as well as SPM #1. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	13.0	13.9	15.9	14.0	14.0
Numerator	95	102	117	104	104
Denominator	733102	733927	736421	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Since 2008 data is not yet available for the numerator and denominator, 2007 death and Census data is used as an estimate.

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Notes - 2006

Source: 2006 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2006 OK population estimates for denominator.

Narrative:
The unintentional death rate among children less than 15 years of age increased by 7.2% to 13.9 per 100,000 population in 2005 from 13.0 in 2004. Generally speaking, this measure tends to vary from year-to-year, oscillating yearly from increases to decreases of moderate change. This is due to the small number of events used to compute the death rate.
/2009/ The unintentional death rate among children less than 15 years of age increased by 13.7% to 15.9 per 100,000 population in 2006 from 13.9 in 2005. Due to the small number of events this measure tends to vary from year-to-year. //2009//
/2010/ The unintentional death rate among children less than 15 years of age decreased by nearly 12% to 14.0 deaths per 100,000 population in 2007 from 15.9 in 2006. Due to the small number of events this measure tends to vary from year-to-year.

See NPM #10 and SPM #8. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.6	4.6	6.7	5.9	5.9
Numerator	41	34	49	44	44
Denominator	733102	733927	736421	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Since 2008 data is not yet available for the numerator and denominator, 2007 death and Census data is used as an estimate.

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Notes - 2006
Source: 2006 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2006 OK population estimates for denominator.

Narrative:

The death rate for children 14 years and younger was 4.6 per 100,000 population in 2005, a reduction of 17.2% from 2004.The death rates in this category tend to vary year-to-year; thus, these findings should be interpreted cautiously, given the small number of events that are used in the computation of these rates. Single-year rates that include small counts of events are subject to wide variability.
/2009/ The death rate for children 14 years and younger climbed to 6.7 per 100,000 population in 2006, a significant increase from 2005, with a rate of 4.6 per 100,000. //2009//
/2010/ The death rate due to unintentional motor vehicle crashes for children 14 years and younger dropped to 5.9 per 100,000 population in 2007, a decrease from the rate of 6.7 in 2006.

See NPM #10 and SPM #8. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	38.5	36.0	38.5	33.8	33.8
Numerator	198	190	202	177	177
Denominator	514379	527537	524450	523251	523251
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Since 2008 data is not yet available for the numerator and denominator, 2007 death and Census data is used as an estimate.

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for denominator.

Notes - 2006
Source: 2006 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2006 OK population estimates for denominator.

Narrative:
The death rate for youth aged 15-24 was down by 6.4%, dropping from 38.5 per 100,000 population in 2004 to 36.0 in 2005. The death rates in this category tend to vary year-to-year; thus, these findings should be interpreted cautiously, given the small number of events that are used in the computation of these rates. Single-year rates that include small counts of events are subject to wide variability.

/2009/ The death rate for youth aged 15-24 increased by 6.9% to 38.5 per 100,000 in 2006 from 36.0 in 2005. //2009//
/2010/ The death rate for youth aged 15-24 dropped by 12.2%, decreasing to 33.8 per 100,000 in 2007 from 38.5 in 2006.

See NPM #10 and SPM #8. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	340.7	340.7	340.7	253.9	253.9
Numerator	2498	2498	2498	1892	1892
Denominator	733102	733102	733102	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: 2008 injury data not available, therefore 2007 data is used as a provisional estimate.

Notes - 2007
Source: Oklahoma inpatient hospital discharge data, 2007, Health Care Information Division, OSDH, for numerator. U.S. Census Bureau July 1, 2007 OK population estimates for denominator.

Notes - 2006
Source: 2006 injury data not available. 2003 nonfatal injury numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2003 OK population estimates for denominator.

Narrative:
The latest nonfatal injury rate for 2003 among children less than 15 years of age was 340.7 per 100,000 population. New data for this measure are not presently available. /2009/ New data for this measure are not presently available. //2009//
/2010/ The latest nonfatal injury rate for 2007 among children less than 15 years of age was 253.9 per 100,000.

See NPM #10 and SPM #8. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	491.5	427.7	440.4	440.4	440.4
Numerator	3603	3139	3258	3258	3258
Denominator	733102	733927	739762	739762	739762
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2008 injury data not available. 2006 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for denominator from Census Bureau.

Notes - 2007
Source: 2007 injury data not available. 2006 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for denominator from Census Bureau.

Notes - 2006
Source: 2006 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for denominator from Census Bureau.

Narrative:
The nonfatal motor vehicle crash rates for age groups 14 and younger declined 13.9% from 2004. /2009/ New data for this measure are not presently available. //2009//
/2010/ The nonfatal motor vehicle crash rates among children ages 14 and younger has increased 3.0% from 427.7 per 100,000 in 2005 to 440.4 in 2006, the latest numbers available.

See NPM #10 and SPM #8. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2,760.5	2,536.9	2,292.2	2,292.2	2,292.2
Numerator	14282	13383	13450	13450	13450
Denominator	517379	527537	586769	586769	586769
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Source: 2008 injury data not available. 2006 injury numbers for ages 15-25 for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for ages 15-25 for denominator from Census Bureau.

Notes - 2007
Source: 2007 injury data not available. 2006 injury numbers for ages 15-25 for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for ages 15-25 for denominator from Census Bureau.

Notes - 2006
Source: 2006 injury numbers for ages 15-25 for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for ages 15-25 for denominator from Census Bureau.

Narrative:
The latest data indicate the nonfatal motor vehicle crash rates for ages 15-24 declined 2.8% from 2004.
/2009/ New data for this measure are not presently available. //2009//
/2010/ The nonfatal motor vehicle crash rate among children ages 15-24 has declined 9.6% from 2,536.9 per 100,000 in 2005 to 2,292.2 per 100,000 in 2006.

See SPM #8. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	32.0	30.3	31.5	29.8	29.8
Numerator	3335	3649	3838	3661	3661
Denominator	104222	120619	121799	122723	122723
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for denominator. 2008 chlamydia data not available, hence 2007 data is used as a provisional estimate.

Notes - 2007
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for denominator.

Notes - 2006
Source: HIV/STD Service, OSDH for numerator, July 1, 2006 Census Bureau estimate for denominator.

Narrative:
The chlamydia case rates for women aged 15-19 rose in year 2006. For ages 15-19, the rate rose 4.2% to 31.5 per 1,000 women from 30.3 in 2005. The period 2002-2003 saw the chlamydia rate remain flat for the teen group, followed by a sharp increase in 2004 (32.0), before decreasing to lower rates in 2005 and 2006.
/2009/ New data for this measure are not presently available. //2009//
/2010/ The chlamydia case rates for women aged 15-19 dropped in 2007. For ages 15-19, the rate decreased 5.3% to 29.8 per 1,000 women from 31.5 in 2006.

MCH works closely with the OSDH HIV/STD Service on a Centers for Disease Control and Prevention (CDC) funded regional infertility project. This project focuses on education, screening and treatment to reduce the incidence of Chlamydia infection in women and men receiving Title X family planning services. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.9	9.1	9.2	9.0	9.0
Numerator	4723	5443	5514	5399	5399
Denominator	597991	595576	601498	602273	602273
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for denominator. 2008 chlamydia data not available, hence 2007 data is used as a provisional estimate.

Notes - 2007
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for denominator.

Notes - 2006
Source: HIV/STD Service, OSDH for numerator, July 1, 2006 Census Bureau estimate for denominator.

Narrative:
The chlamydia rate among the older age group rose sharply (19.7%) between 2002 and 2003, leveled off between 2003 and 2004, rose steeply (56.9%) again between 2004 and 2005, before rising at a more moderate rate in the year between 2005 and 2006.
/2009/ The chlamydia rate for women aged 20-44 increased 1.1% to 9.2 per 1,000 women in 2006 from 9.1 in 2005. //2009//
/2010/ The rate for women aged 20-44 decreased 2.2% to 9.0 per 1,000 women in 2007 from 9.2 in 2006.

MCH works closely with the OSDH HIV/STD Service on a Centers for Disease Control and Prevention (CDC) funded regional infertility project. This project focuses on education, screening and treatment to reduce the incidence of Chlamydia infection in women and men receiving Title X family planning services. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	55590	38638	5567	4909	1076	80	5320	0
Children 1 through 4	210957	151040	20249	21179	3217	322	14950	0
Children 5 through 9	248202	180201	24005	23742	3772	376	16106	0
Children 10 through 14	239121	172213	23973	24656	3805	291	14183	0
Children 15 through 19	251880	180993	26382	27256	3775	277	13197	0
Children 20 through 24	270201	198736	26424	26452	6317	317	11955	0
Children 0 through 24	1275951	921821	126600	128194	21962	1663	75711	0

Notes - 2010

Narrative:
According to the American Community Survey (ACS), in 2006, the latest for which detailed race/ethnicity data are available, there were an estimated 1,271,287 children in Oklahoma between the ages 0 and 24. Four percent were infants and 16% were children ages 1-4. Approximately 19% were children ages 5-9, with another 19% aged 10-14 years and 20% aged 15-19. Roughly 21% of the 1.3 million children were aged 20-24. Nearly three quarters (73%) of Oklahoma children are classified as White, with another 10% considered American Indian/Native Alaskan and 10% African American. Less than 2% of Oklahoma children are classified as Asian race.
/2009/ No new data are available. //2009//
/2010/ According to the ACS, in 2007, the latest for which detailed race/ethnicity data are available, there were an estimated 1,275,951 children in Oklahoma between the ages 0 and 24. Four percent were infants and nearly 17% were children ages 1-4. Over 19% were children ages 5-9, with another 19% aged 10-14 years and 20% aged 15-19. Roughly 21% of the 1.3 million children were aged 20-24. The fraction of Oklahoma's population under 25 years of age has declined slightly over the past nine years, from 36.2% in 2000 to 35.0% in 2008. Nearly three quarters (72%) of Oklahoma children of ages 0-24 years are classified as White, with another 10% American Indian/Native Alaskan and 10% African American. Less than 2% of Oklahoma children are classified as Asian race. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	47988	7602	0
Children 1 through 4	178896	32061	0
Children 5 through 9	215744	32458	0
Children 10 through 14	213592	25529	0
Children 15 through 19	229371	22509	0
Children 20 through 24	247792	22409	0
Children 0 through 24	1133383	142568	0

Notes - 2010

Narrative:
In 2006, the latest for which detailed race/ethnicity data are available, the ACS data reveal that 10.3% of Oklahoma children aged 0 through 24 years are of Hispanic origin.
/2009/ No new data are available. //2009//
/2010/ More than eleven percent of Oklahoma children aged 0 through 24 years are of Hispanic origin. The fraction of Oklahoma children who are Hispanic has grown by 40% during the past nine years, from 8% in 2000 to 11.2% in 2008. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	89	48	24	15	0	2	0	0
Women 15 through 17	2268	1515	333	400	0	20	0	0
Women 18 through 19	5120	3553	660	862	2	43	0	0
Women 20 through 34	41871	32395	3727	4839	91	819	0	0
Women 35 or older	4385	3499	300	312	37	237	0	0
Women of all ages	53733	41010	5044	6428	130	1121	0	0

Notes - 2010

Narrative:
In 2005, the latest year for which final birth data are available, there were 51,775 births to Oklahoma residents, a negligible change from the number of births in 2004 (n=51,683).

Approximately 13% of Oklahoma births are to women under the age of 20, resulting in no real change in the proportion of all births occurring to this age group. Another 8% of births occur to women 35 or older, with the remaining births occurring to women aged 20-34 years.

Nearly 8 in 10 births (77%) in Oklahoma occur to white mothers. African American and Native American births make up 9.3% and 11.3%, respectively, of all Oklahoma births. Just 2% of Oklahoma births are births occurring to women of Asian descent.
/2009/ In 2006, the latest year for which final birth data are available, there were 54,010 live births to Oklahoma residents. This represents a 4.3% increase over the number of births in 2005 (n=51,775). Nearly 8 in 10 births (77%) in Oklahoma occur to white mothers. African American and Native American births make up 9.3% and 11.2%, respectively, of all Oklahoma births.

The Oklahoma birth rate among children of ages 17 or under has increased by over ten percent from 2.4 births per 1,000 in 2005 to 2.7 in 2006. The 2006 birth rates in the African American and Native American population ages 17 or under were 4.2 births per 1,000 and 4.3 births per 1,000, respectively, considerably higher than the White birth rate of 2.5. //2009//
/2010/ In 2007, the latest year for which final birth data are available, there were 54,946 live births in Oklahoma. This represents a 1.7% increase over the number of births in 2006 (n=54,010).

The Oklahoma birth rate among children of ages 17 or under has remained at 2.7 live births per 1,000 in 2007, the same as 2006. The teen birth rate fell to a low of 2.4 live births per 1,000 in 2005 from 2.9 in 2000, but has since increased in 2006 and 2007. The 2007 birth rates in the African American and Native American population ages 17 or under were 4.3 births per 1,000 and 4.7 births per 1,000, respectively, considerably higher than the White birth rate of 2.4.

Nearly 8 in 10 births (76.7%) in Oklahoma occur to white mothers. African American and Native American births make up 9.2% and 11.8%, respectively, of all Oklahoma births. Just 2.3% of Oklahoma births are births occurring to women of Asian or Pacific Islander descent. 13.0% of births are of Hispanic origin.

The Oklahoma crude birth rate increased slightly from 2006 to 2007, from 15.1 to 15.2 live births per 1,000. Oklahoma has seen an increase of 5.5% in the crude birth rate during the past nine years.

The White birth rate remained at 14.5 live births per 1,000 in 2006 and 2007. The African-American birth rate decreased slightly from 16.4 to 16.2 live births per 1,000. The Native American and Asian/Pacific Islander crude birth rates both increased from 2006 to 2007, from 19.0 to 20.3 live births per 1,000 among Indians and 16.1 to 17.8 live births per 1,000 among Asians. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	63	26	0
Women 15 through 17	1800	464	4
Women 18 through 19	4427	687	6
Women 20 through 34	36625	5197	49
Women 35 or older	3754	623	8
Women of all ages	46669	6997	67

Notes - 2010

Narrative:
In 2005, the latest year for which final birth data are available, there were 51,775 births to Oklahoma residents. This represents a negligible change over the number of births in 2004 (n=51,683).

Approximately 13% of Oklahoma births are to women under the age of 20, resulting in no real change in the proportion of all births occurring to this age group. Another 8% of births occur to women 35 or older, with the remaining births occurring to women aged 20-34 years.

Just over 12% of births are of Hispanic origin. Hispanic births are the fastest growing race/ethnic birth group in Oklahoma.
/2009/ The Hispanic population showed the highest birth rate among teens of ages 17 or under at 4.9 births per 1,000 in 2006, compared with the Non-Hispanic birth rate of 2.4 births per 1,000. //2009//
/2010/ The Hispanic population showed the highest birth rate among teens of ages 17 or under at 4.2 births per 1,000 in 2007, compared with the Non-Hispanic birth rate of 2.4 births per 1,000.

Much of the increase in crude birth rate may be attributed to the growing Hispanic population in Oklahoma. Hispanic births continue to be the fastest growing race/ethnic birth group in Oklahoma. The crude birth rate in the Hispanic population was 27.4 births per 1,000 in 2007, nearly twice the crude birth rate of 14.2 births per 1,000 for Non-Hispanics. The Hispanic birth rate decreased by 3.9% from 2006 to 2007, compared with an increase of 1.1% among the Non-Hispanic population, from 14.0 to 14.2 live births per 1,000. Despite fluctuations from year to year, the Hispanic birth rate has risen by almost fourteen percent since 2000. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	422	254	80	49	1	1	0	37
Children 1 through 4	98	62	10	12	2	0	0	12
Children 5 through 9	46	26	8	9	1	0	0	2
Children 10 through 14	64	42	8	9	1	0	0	4
Children 15 through 19	260	164	34	41	2	0	0	19
Children 20 through 24	321	206	40	46	3	2	0	24
Children 0 through 24	1211	754	180	166	10	3	0	98

Notes - 2010

Narrative:
In 2004, there were 1,139 deaths to children 0 to 24 years of age. This is a slight increase of 2% from 1,113 in 2004. Thirty-seven percent of the child deaths occur to infants. Young adults aged 20-24 make up the second largest proportion (27.4%) of deaths to children 0-24. Another 20% of child deaths occur to the adolescent age group 15-19 years. Nearly 3 in 4 (72.4%) child deaths occur to White children. African American and Native American children make up 13.7% and 12.4% of the Oklahoma child deaths in 2005.
/2009/ In 2006, there were 1,235 deaths to children 0 to 24 years of age. This is an increase of 8.4% from 1,139 in 2005, yet is only a minor increase of 0.9 deaths per 1,000 in 2005 to 1.0 deaths per 1,000 in 2006 among children 0 to 24 years of age. Thirty-seven percent of the child deaths occur to infants. Young adults aged 20-24 make up the second largest proportion (26.7%) of deaths to children 0-24. Another 18.2% of child deaths occur to the adolescent age group 15-19 years.

Sixty four percent of child deaths occurred to White children in 2006. African American and Native American children make up 14.0% and 13.6% of the Oklahoma child deaths in 2006. African American and Native American children in Oklahoma had mortality rates of 1.4 deaths per 1,000 and 1.3 deaths per 1,000 in 2006, respectively, significantly higher than White mortality rate of 0.9 deaths per 1,000. //2009//
/2010/ In 2007, there were 1,159 deaths to children 0 to 24 years of age. This is a decrease of 6.2% from 1,235 deaths in 2006. There was a decrease in the death rate among children ages 0-24, from 1.0 deaths per 1,000 in 2006 to 0.9 deaths per 1,000 in 2007. Forty percent of the child deaths occurred to infants. Young adults aged 15-24 made up 43.7% of deaths to children 0-24. Another 9.6% of child deaths occurred in the age group 5-14 years.

The death rate among children 0 to 24 years of age has increased by over 11% since 2000, when the rate was 0.8 deaths per 1,000. Much of the increase during this period is explained by a significant increase of 24% in the death rate among African-American children, from 1.3 deaths per 1,000 in 2000 to 1.6 in 2007, and a steep increase of 70% in the death rate among Native American children, from 0.6 deaths per 1,000 in 2000 to 1.1 in 2007.

Seventy percent of child deaths occurred to White children in 2007. African American and Native American children make up 17.3% and 12.2% of the Oklahoma child deaths in 2006. African American and Native American children in Oklahoma had mortality rates of 1.6 deaths per 1,000 and 1.1 deaths per 1,000 in 2006, respectively, significantly higher than White mortality rate of 0.9 deaths per 1,000.

MCH provides leadership for multiples activities to impact this HSI (e.g. Child Death Review Board, Fetal and Infant Mortality Review, Injury Workgroup of Commissioner's Action Team on Reduction of Infant Mortality). Also see NPMs #10 and #16 and SPM #8. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	342	49	4
Children 1 through 4	80	17	1
Children 5 through 9	40	3	0

Children 10 through 14	55	6	0
Children 15 through 19	223	25	0
Children 20 through 24	275	24	7
Children 0 through 24	1015	124	12

Notes - 2010

Narrative:
About 9% of child deaths occur to children of Hispanic origin.
/2009/ About 8% of child deaths occur to children of Hispanic origin. //2009//
/2010/ About 8% of child deaths occurred to children of Hispanic origin in 2007. Hispanic children aged 0-24 years had a mortality rate of 0.7 deaths per 1,000 in 2007, compared with a death rate of 0.9 among Non-Hispanic children. The Hispanic death rate increased from 0.6 in 2000 to a peak of 1.0 in 2003, then declined to 0.7 in 2007. The Non-Hispanic death rate has increased slightly during this period, from 0.8 deaths per 1,000 in 2000 to 0.9 in 2007.

MCH provides leadership for multiples activities to impact this HSI (e.g. Child Death Review Board, Fetal and Infant Mortality Review, Injury Workgroup of Commissioner's Action Team on Reduction of Infant Mortality). Also see NPMs #10 and #16 and SPM #8. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1005750	723085	100176	101742	15645	1346	63756	0	2008
Percent in household headed by single parent	32.9	26.9	67.0	36.2	16.6	0.0	43.4	33.8	2006
Percent in TANF (Grant) families	1.6	0.9	5.5	2.0	0.8	0.0	0.0	0.0	2008
Number enrolled in Medicaid	514441	349553	79432	69532	6379	495	9050	0	2008
Number enrolled in SCHIP	114322	83540	11473	16258	1676	70	1305	0	2008
Number living in foster home care	10427	5622	2720	2037	48	0	0	0	2008
Number enrolled in	390047	256812	77307	52321	3607	0	0	0	2008

food stamp program									
Number enrolled in WIC	189763	136319	22900	2058	13164	884	14438	0	2008
Rate (per 100,000) of juvenile crime arrests	2169.3	1957.3	6090.3	1403.6	869.3	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.9	2.6	3.3	3.0	2.2	0.0	0.0	0.0	2008

Notes - 2010
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Source: Oklahoma State Department of Health - WIC.

Narrative:
Nearly 1 in 4 (23.6%) Oklahoma children aged 0 to 19 live in a single-parent household. Rates differ rather dramatically by race: White 19.7%, African American 49.3% and Native American 25.4%.

Approximately 33% of Oklahoma children in this age group are enrolled in the Medicaid program, while 10.7% are enrolled in the Oklahoma's State Children's Health Insurance Program (SCHIP). Roughly 62% of the children enrolled in the Medicaid program are White. African American and Native American children comprise 20% and 16%, respectively, of child Medicaid enrollees. The primary groups in the racial distribution for SCHIP enrollees are 70% White, 12% African American and 17% Native American.
/2009/ Nearly 1 in 3 (32.9%) of Oklahoma children aged 0 to 19 live in a single-parent household in 2006: White 26.9%, African American 67.0% and Native American 36.2%.

Approximately 11% of Oklahoma children in this age group were enrolled in the Oklahoma SCHIP in 2007. Roughly 69% of the children enrolled in the SCHIP are White. African American and Native American children comprise 12% and 17%, respectively, of child SCHIP enrollees.

Over forty percent (42.4%) of children 0 to 19 years of age in Oklahoma were enrolled in a food stamp program during 2007, and nearly 19% were enrolled in WIC. The juvenile crime rate in Oklahoma stood at 2,421 juvenile crime arrests per 1,000 among this age range. The juvenile crime rate among White children is 2,191 arrests per 1,000, while the crime rate for African-American youth is over three times higher, at 6,850 arrests per 1,000. //2009//
/2010/ Approximately 51% of Oklahoma children in this age group were enrolled in the Medicaid program in 2008, while 11.4% were enrolled in the Oklahoma SCHIP program. Roughly 68% of the children enrolled in the Medicaid program were White. African American and Native American children comprised 15% and 14%, respectively, of child Medicaid enrollees.

Over thirty-eight percent (38.8%) of children 0 to 19 years of age in Oklahoma were enrolled in a food stamp program during 2008, and nearly 19% were enrolled in WIC. The juvenile crime rate in Oklahoma stood at 2,169 juvenile crime arrests per 1,000 among this age range. The juvenile crime rate among White children is 1,957 arrests per 1,000, while

the crime rate for African-American youth is over three times higher, at 6,090 arrests per 1,000.

The percentage of Oklahoma children in grades 9-12 who dropped out of school was 2.9% in 2008, with Whites showing a 2.6% dropout rate, African-Americans 3.3%, and Native Americans 3.0%. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	885591	120159	0	2008
Percent in household headed by single parent	26.5	33.8	0.0	2006
Percent in TANF (Grant) families	1.6	1.7	0.0	2008
Number enrolled in Medicaid	441250	73191	0	2008
Number enrolled in SCHIP	97748	16574	0	2008
Number living in foster home care	10427	1681	0	2008
Number enrolled in food stamp program	390047	25350	0	2008
Number enrolled in WIC	136885	52878	0	2008
Rate (per 100,000) of juvenile crime arrests	2251.8	1561.3	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.8	4.8	0.0	2008

Notes - 2010
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Source: Oklahoma State Department of Health - WIC.

Narrative:
Ten percent of the child population 0 to 19 years of age are considered Hispanic. The Hispanic rate (23.3%) of single-parent households does not differ from the overall race proportion. Hispanic children make up 14.0% of the child Medicaid enrollees and 15% of SCHIP enrollees. /2009/ Ten percent of children 0 to 19 years of age are considered Hispanic. The Hispanic rate (33.8%) of single-parent households in 2006 does not differ significantly from the overall race proportion. Hispanic children made up 16% of the child Medicaid enrollees and 16% of SCHIP enrollees in 2007. The juvenile crime rate among Hispanic youths was 1,864 arrests per 1,000 in 2007. Hispanic children have the highest dropout rate of 6.4% for grades 9-12, compared with 3.7% for Non-Hispanic children. //2009//
/2010/ 11.9% of children 0 to 19 years of age are considered Hispanic. Hispanic children made up 14% of the child Medicaid enrollees and 14% of SCHIP enrollees in 2008. The juvenile crime rate among Hispanic youths was 1,561 arrests per 1,000 in 2008. Hispanic children have the highest dropout rate of 4.8% for grades 9-12, compared with 2.8% for Non-Hispanic children. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	655482
Living in urban areas	662626
Living in rural areas	332765
Living in frontier areas	10359
Total - all children 0 through 19	1005750

Notes - 2010
Source: U.S. Census Bureau. Metropolitan population calculated from July 1, 2008 population estimate of children 0-19 years of age residing in Oklahoma MSA counties.

Source: U.S. Census Bureau. Urban population calculated from total number of children 0-19 years of age residing in Oklahoma counties with July 1, 2008 population estimate> 50,000.

Source: U.S. Census Bureau. Rural population calculated from total number of children 0-19 years of age residing in Oklahoma counties with July 1, 2008 population estimate < 50,000, excluding frontier rural counties.

Source: U.S. Census Bureau. Frontier rural population calculated from total number of children 0-19 years of age residing in Oklahoma counties with 2008 population density < 7 people per square mile.

Narrative:
Data for this Health Status Indicator were provided by the Oklahoma Department of Commerce, which extracts the information from the American Community Survey (ACS) conducted be the U.S. Census Bureau. In 2005, there were an estimated 964,459 children aged 0-19 in the state of Oklahoma, a decline of less than 1% from 965,850 children in 2004. Approximately 64% of these children reside in metropolitan areas. This percentage is unchanged from 2004. Sixty-five percent of Oklahoma children live in urban areas, with the remainder living in rural (34.4%) and frontier (0.7%). Overall, there was no observed shift in the percentage of children living in these defined geographic areas.
/2009/ In 2006, ACS data estimated 990,667 children aged 0-19 lived in Oklahoma, a growth of 2.7% from 964,459 children in 2005. Approximately 65% of these children reside in metropolitan areas. Sixty-four percent of Oklahoma children live in urban areas, with the remainder living in rural (35.1%) and frontier (1.1%). Once again there was no significant shift in the percentage of children living in these defined geographic areas. //2009//
/2010/ In 2008, ACS data estimated 1,005,750 children aged 0-19 lived in Oklahoma, a growth of 1.5% from 990,667 children in 2006. Approximately 65% of these children reside in metropolitan areas. Sixty-six percent of Oklahoma children live in urban areas, with the remainder living in rural (33.0%) and frontier (1.0%). This most recent geographic population data shows a small increase in the proportion of children residing in urbanized areas of the State. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3642361.0
Percent Below: 50% of poverty	5.0
100% of poverty	13.4
200% of poverty	36.3

Notes - 2010
Source: U.S. Census Bureau 7/1/2008 State Characteristics Population Estimates.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Narrative:
The Oklahoma Department of Commerce provided these Health Status Indicator data. The U.S. Census Bureau through the American Community Survey (ACS) collected this information. In 2005, there were an estimated 3,420,671 individuals residing in Oklahoma, a slim decline of less than 1% from 2004. Changes in Oklahoma poverty levels were mixed in 2005. The percent of Oklahomans under 50% of the federal poverty level (FPL) dropped to 7.0% from 7.4%. The percent of Oklahomans at or below 100% rose from 15.3% to 16.5% and those at or below 200% rose from 37.5% to 38.1% of FPL between 2004 and 2005.
/2009/ According to the ACS in 2006, there were an estimated 3,488,814 individuals residing in Oklahoma, an increase of 2.0% from 2005. Oklahoma showed an improvement in poverty levels during 2006. The percent of Oklahomans under 50% of the federal poverty level (FPL) dropped to 6.8% from 7.0%. The percent of Oklahomans at or below 100% dropped from 16.5% to 15.2% and those at or below 200% decreased from 38.1% to 37.5% of FPL between 2005 and 2006. //2009//
/2010/ According to the ACS in 2008, there were an estimated 3,642,361 individuals residing in Oklahoma, an increase of 4.4% from 2006. Oklahoma showed another year of improvement in poverty levels during 2008. The percent of Oklahomans under 50% of the federal poverty level (FPL) dropped to 5.0% from 6.8%. The percent of Oklahomans at or below 100% dropped from 15.2% to 13.4% and those at or below 200% decreased from 37.5% to 36.3% of FPL between 2006 and 2008. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1005750.0
Percent Below: 50% of poverty	7.5
100% of poverty	18.8
200% of poverty	45.3

Notes - 2010
Source: U.S. Census Bureau 7/1/2008 State Characteristics Population Estimates.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2008.

Narrative:
Data were provided by the Oklahoma Department of Commerce, which extracted the information from the U.S. Census Bureau through the American Community Survey. In 2005, the percent of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) rose to 11.0% from 10.2% in 2004. Likewise, the percent of children in Oklahoma at or below 100% and 200% of FPL increased between 2004 and 2005, from 21.1% to 23.5% to 48.7% to 52.7% respectively.
/2009/ ACS data indicate that in 2006 the percent of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) dropped to 8.9% from 11.0% in 2005. Likewise, the percent of children in Oklahoma at or below 100% and 200% of FPL decreased between 2005 and 2006, from 23.5% to 22.2% and 52.7% to 50.0%, respectively. //2009//
/2010/ ACS data indicate that in 2008 the percent of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) saw a decrease to 7.5% from 8.9% in 2006. Likewise, the percent of children in Oklahoma at or below 100% and 200% of FPL between 2006 and 2008 also decreased, from 22.2% to 18.8% and 50.0% to 45.3%, respectively. //2010//

F. Other Program Activities

MCH continues to provide MCH comprehensive program reviews to county health departments and contract providers. Each health department site is on a four-year rotating schedule to receive a comprehensive program review. Technical assistance visits and a self-assessment by each site are completed in interim years. Contract providers receive a comprehensive program review every four years with routine contract monitoring visits conducted in each interim year. The MCH Comprehensive Program Review involves a multidisciplinary team traveling to an Administrator's area or a contract provider's clinical site(s) to assess infrastructure, population-based, enabling and direct health services. A comprehensive report is prepared and forwarded to Administration of the county health department or contract agency outlining requirements and recommendations as well as timelines for addressing findings. MCH provides ongoing technical assistance in addressing areas of concern.

CSHCN continues to provide site visits to all contract providers. The main focus at these visits is to discuss how contractor activities are tied to the national and state performance measures of CSHCN.

Injury prevention activities continue to be a focus. MCH provides technical assistance and state funding for the Oklahoma Poison Control Center. MCH will work closely with Safe Kids, Inc. to facilitate growth of local Safe Kids coalitions. MCH and CSHCN actively participate on the Traumatic Brain Injury (TBI) Advisory Committee. MCH and CSHCN will assure ongoing involvement with TBI activities accomplished through a Maternal and Child Health Bureau (MCHB) Grant received by the Oklahoma State Department of Health (OSDH) Injury Prevention Service. Recently implemented quarterly MCH and Injury Prevention Service meetings will also facilitate interaction/support of TBI activities.

/2009/ Planning continues with Safe Kids Oklahoma as it pursues strengthening and expanding local injury prevention coalitions. Collaboration with Injury Prevention Service continues on crosscutting injury prevention activities to include TBI activities. //2009//
/2010/ Quarterly planning meetings continue with Injury Prevention Service. //2010//

Activities targeted toward prevention of Sudden Infant Death Syndrome (SIDS) remain a priority. The Public Health Social Work Coordinator coordinates these activities out of MCH working closely with intra and interagency groups as well as families who have been impacted by a SIDS death.
/2009/ MCH is focusing on infant safe sleep with the increased number of deaths occurring due to unsafe sleep conditions that might have contributed to the deaths. In collaboration with the Oklahoma Child Death Review Board and the Oklahoma Department of Human Services (OKDHS), a media campaign is being developed regarding infant safe sleep. In collaboration with OKDHS, an educational display has been developed and is being used to educate the general public and policy makers on infant safe sleep. Work is in process to complete a hospital survey of all nursing staff working labor and delivery, postpartum, nursery and neonatal intensive care units. The survey will explore their knowledge of their facilities written policies on safe sleep, staff training provided on infant safe sleep to include placing infants on their backs to sleep and education provided to parents prior to discharge. MCH is also developing, in collaboration with the Perinatal Continuing Education Program at the University of Oklahoma Health Sciences Center, a model hospital infant safe sleep policy and nursing curriculum. //2009//
/2010/ A new state performance measure was added this year. See SPM #11. //2010//

MCH will continue to provide funding to ongoing activities of the Oklahoma Birth Defects Registry (OBDR). The OBDR is a public health surveillance program that monitors the status of children born with birth defects in Oklahoma. Characteristics of the OBDR include: statewide, population based, active surveillance; Oklahoma residents who deliver babies in Oklahoma; age range includes birth to 2 years of age; all live births and stillbirths diagnosed with a birth defect (CDC/BPA codes). Activities of the OBDR consist of referral of children with birth defects to the SoonerStart (Oklahoma's zero to three early intervention program), statewide folic acid education campaign for neural tube defect (NTD) prevention and rapid ascertainment of babies born with NTDs from tertiary hospitals, including recurrence prevention education of NTDs.

In addition to administering the statewide-randomized Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) in odd numbered years, MCH continues to offer, in even numbered years, the YRBS to local schools who request the survey. This provides the local school with information to use in planning for activities and programs to impact youth risk-taking behaviors.

MCH is currently working with the CDC on revisions to the Phase VI Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire. The revised PRAMS questionnaire will be used beginning January 2009.
/2009/ The Phase VI Oklahoma PRAMS survey has been finalized. Several new topics were added, such as reasons for caesarian section births and emergency room use for prenatal care. Revisions to The Oklahoma Toddler Survey (TOTS) will begin in April. //2009//
/2010/ Revisions to TOTS has been rescheduled to begin late summer. //2010//

Revisions are also being accomplished on Oklahoma's First Grade Health Survey. Plans are to administer the survey to parents/guardians of children in first grade in public schools statewide in the fall of this upcoming 2007/2008 school year.
/2009/ The First Grade Health Survey was administered this spring with analysis of data to occur during the summer 2008. Results will be released through topical reports that address specific priorities for the health of early school-age children. Reports will be distributed to elementary schools across the state to inform teachers and school leaders of the health concerns of young public school children. Also, the data will be shared with health partners to provide a status report specific to the needs of Oklahoma's first graders. The Fifth Grade Health Survey is under revision

and will be administered fall 2008. Results will be disseminated in a similar fashion as planned for the First Grade Health Survey. //2009//
/2010/ The surveys have been placed on a rotating schedule with the First Grade Health Survey to be administered in the fall of odd years and the Fifth Grade Health Survey in the fall of even years. //2010//

MCH is providing support to the Oklahoma Vision Screening Advisory Committee for Children created last legislative session through Senate Bill 1795. MCH has provided leadership in development of OSDH Board of Health rules this year. Currently training and education to facilitate statewide implementation of vision screening of kindergarten, first and third grade children in public schools during the 2007/2008 school year is occurring.
/2009/ MCH provided vision screening training to over 100 school nurses across the state during this school year and will conduct vision screening training as requested during the 2008-2009 school year. MCH will continue to work with the Oklahoma Vision Screening Advisory Committee for Children to provide technical assistance during the 2008-2009 school year. //2009//
/2010/ State statute and OSDH Board of Health rules were revised this year to clarify policy and procedures. //2010//

House Bill 1051, passed this year by the 2007 Legislature and signed by the Governor, creates the Diabetes Management in Schools Act. This Act requires that a diabetes medical management plan be developed for each student with diabetes who will seek care for diabetes while at school or while participating in a school activity. MCH will be working with state partners and stakeholders to develop policy and procedure to implement the provisions of this law over the current state fiscal year.
/2009/ During the school year, MCH collaborated with Chronic Disease and OSDE to provide diabetes management training for school personnel throughout the state. Eight trainings were held with over 1,000 school personnel trained in the state standards for the management of the diabetic student in schools. MCH will provide training to school staff across the state during the 2008-2009 school year on the management of the diabetic student in schools. //2009//
/2010/ Diabetes trainings were provided spring 2009 to 295 individuals representing 121 schools. With increased demand, MCH will be providing 3 trainings in fall 2009 and 3 trainings in spring 2010; double the number from this past year. //2010//

G. Technical Assistance

MCH and CSHCN are currently in discussion with Family Voice, Inc. regarding planned technical assistance to occur before the end of September. MCH and CSHCN will be inviting representatives of Oklahoma family organizations and family advocates from state and community-based organizations to participate in a one to two day technical assistance visit to be facilitated by Family Voices, Inc. The outcome of the technical assistance is to identify strategies to more actively involve families in MCH and CSHCN activities as well as other Oklahoma State Department of Health (OSDH) and Oklahoma Department of Human Services (OKDHS) activities as opportunities present. It is also anticipated that MCH and CSHCN will learn more about support that is needed to enhance/sustain a viable statewide family network that can have a strong voice in state and community level policy and services.
/2009/ On April 26, 2008 the Joining Forces: Supporting Family/Professional Partnership Conference was held in Oklahoma City. This conference was a result of the technical assistance received from Family Voices, Inc. in September 2007. Goals of the conference were to: 1) increase the awareness of the importance of family/professional partnerships; 2) increase family participation in the development, implementation and evaluation of programs; 3) increase leadership and partnership skills; and, 4) identify opportunities for family leadership. The conference was a first step in development of a statewide network of families who are interested in partnering with state agencies and organization to provide input on the development, implementation and evaluation of programs. The conference presented the opportunity for state agencies/organizations and families to learn from each other and to link with one another based on needs and interests. //2009//

/2010/ The second annual Joining Forces Conference was held April 25, 2009. See III. State Overview, E. State Agency Coordination //2010//

MCH requested and received approval in June from the Maternal and Child Health Bureau for technical assistance in developing this year's annual state plan for the reduction of adolescent pregnancy and sexually transmitted diseases (STDs). More specifically, MCH made this request on behalf of the Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs (ICC), a legislatively appointed interagency group on which the Chief of MCH and Adolescent Health Coordinator participate. David Knapp, a consultant from North Carolina, will be facilitating a one and a half day strategic planning meeting of the council on September 26-27, 2007. The outcome of the strategic planning meeting will be development of a written state plan that MCH and the Chair of the ICC look to set a strong foundation for the future direction of prevention activities for the state for the next several years.

Technical assistance will be requested during the 2008 grant year from the Konopka Institute for Best Practices in Adolescent Health at the University of Minnesota through the Maternal and Child Health Bureau. This technical assistance will assist MCH and CSHCN in completion of the System Capacity Tool for Adolescent Health. Information gained will be used to develop a strategic plan for adolescent health in Oklahoma.
/2009/ The technical assistance received from David Knapp was instrumental in development of a written state plan that the ICC for the Prevention of Adolescent Pregnancy and STDs has implemented and is being used as the basis for action. The technical assistance also provided the opportunity to restructure some of the internal operations of the ICC facilitating more active and effective involvement of council members.

Currently, the MCH Adolescent Health Coordinator is working closely with staff from the Konopka Institute to conduct a systems capacity assessment that will be used in identifying next steps to strengthen the infrastructure in addressing adolescent health needs. //2009//
/2010/ See NPM #8 //2010//

MCH and CSHCN are also currently involved with a state review being conducted by the Region VI Health and Human Resources Services Administration (HRSA) Office of Performance Review (OPR). Staff from the Dallas Regional Division met with staff from MCH, CSHCN, OSDH Primary Care and Rural Health Development, OSDH HIV/STD Service, Oklahoma Primary Care Association and Oklahoma Office of Rural Health initially in Oklahoma on May 14, 2007. The HRSA OPR is working with these HRSA grantees to identify a common crosscutting health issue and providing technical assistance as the state HRSA partners move through this performance review process. Routine communication is occurring via e-mail and conference calls with a final face-to-face meeting to occur in Oklahoma in August.
/2009/ The final meeting of the Region VI HRSA OPR occurred August 8, 2007 with a commitment made by the Oklahoma HRSA funded programs to continue with their existing ongoing collaboration and within this to look for additional opportunities for collaboration. //2009//

At this time, no additional technical assistance request(s) is planned. As technical assistance activities described move forward, MCH and CSHCN will look to utilize the process for requesting technical assistance for 2008 as the need(s) arises.
/2009/ MCH and CSHCN will look to utilize the process for requesting technical assistance for 2009 as the need(s) arise. //2009//
/2010/ MCH and CSHCN will look to more specifically engage other Oklahoma Title V grantees through our routinely scheduled MCH/CSHCN collaboration meetings during the upcoming grant period. A request will be made to each grantee to meet with MCH and CSHCN to share crosscutting grant activities and discuss opportunities for enhancing the health of MCH populations, inclusive of CSHCN. Request(s) for technical assistance may arise from these interactions. //2010//

V. Budget Narrative

A. Expenditures

See Forms 2, 3, 4 and 5

The Oklahoma State Department of Health (OSDH) and Oklahoma Department of Human Services (OKDHS) continue to improve verification and reporting of how resources are actually budgeted and spent. Both the OSDH and OKDHS have participated in designing and implementing better methods of defining resource allocation and expenditure. Prior to the 2002 report and 2004 application, all Children With Special Health Care Needs (CSHCN) resources were reported as direct services because no method had been devised to allocate these resources differently. This resource allocation was revised beginning with the 2002 annual report and 2004 application to more accurately reflect true occurrence. The same is true for parts A and B, but with a lesser impact.

OSDH Maternal and Child Health (MCH) value for parts A, B and C is determined through the OSDH time and effort reporting system in which all state and local staff code their daily time to program activities. Non-personnel expenses are made as direct charges to the appropriate program budgets. State funds include state and county appropriations for local health departments. Other contributions include in-kind monies. Program income includes fee revenues from Title XIX. Only one contract agency currently uses fee schedules for maternity and child health services. These fee schedules are reviewed and approved by MCH. The fee schedules are based on federal poverty level (FPL), family income and family size. Clients below 100% FPL are not charged for services and no one is refused services based on inability to pay. The agency is audited each year by the state auditor's office following the federal guidelines applicable to the Title V MCH Block Grant. All appropriate fiscal records are maintained to insure audit compliance.

/2010/ Oklahoma, as most states in the nation, is experiencing a state budget deficit. Reductions passed on to the OSDH through this year's legislative state appropriation process are expected to impact the final total effort documented this year to the Title V MCH Block Grant as well as future years until there is a positive turn in the economy. //2010//

OKDHS CSHCN value is determined through the Random Moment Time Study (RMTS) and based on employees' responses specifically related to the CSHCN Program. All Field Operations Division and Family Support Services Division field staff that work multi-funded programs are sampled in the RMTS. RMTS sampling is a federally approved technique for estimating the actual distribution of worker time to various activities when numerous federal funding sources exist. The percentage of employees' responses to CSHCN-related tasks compared to responses to all other federal and/or state programs in the RMTS constitutes the value of costs directly charged quarterly to the CSHCN Program. Payroll, benefits, travel, etc., for RMTS participants are allocated proportionately based on RMTS responses.

Within the overall federal portion of Title V MCH Block dollars committed to Maternal and Infant Health, Preventative and Primary Care for Children, and Children with Special Health Care Needs, efforts continue as opportunities present to realign funding for core infrastructure, population-based and enabling services and less towards direct health care services (see Figure 2).

/2009/ There are no changes. //2009//

/2010/ On April 1, 2008 Soon-To-Be-Sooners, a new benefit under Medicaid, was implemented. This new benefit provides coverage of pregnancy related medical services for pregnant women who meet all SoonerCare eligibility requirements other than those for citizenship. This new stream of funding to support maternity direct health care services is allowing MCH to realign funds historically utilized for clinical services to population-based

and infrastructure services. A specific focus within this realignment will be strengthening activities to impact infant mortality and morbidity. //2010//

B. Budget

Maintenance of effort from 1989:
For 1989, the OSDH administered 77.5% of the Title V MCH Block Grant funds and the OKDHS administered 22.5% of the funds. Even with this split, 1/3 of the available dollars were spent on CSHCN activities. The amount of the award for 1989 was $5,980,100. The OSDH share was $4,634,578 and the OKDHS received $1,345,522.

The OSDH expenditure reports indicate that a total of $4,634,578 of Title V MCH Block funds was expended during the grant period October 1, 1988 through September 30, 1989. For that period, a total $4,109,415 of the OSDH and county health department resources were expended for Block Grant activities. The amount of state/local expenditures exceeded the required match of $3,475,932 by an amount of $633,483.

Summary -- FY1989 Block Grant Expenditures

	State Health Department	Department of Human Services	Total
Title V	$4,634,578	$1,345,522	$5,980,100
Match	$3,475,932	$1,061,546	$4,537,478
Overmatch	$146,839	0	$146,839
Income	$250,000	0	$250,000
Local/Other	$236,644	0	$236,644
Total	$8,743,993	$2,407,068	$11,151,061

Special consideration for funding pre-1981 projects:
Prior to the Title V MCH Block Grant, MCH funded a combined Maternal and Infant Care, Children & Youth and Dental Project in an urban area. Title V MCH Block Grant funds continue to fund these programs although they have evolved from the "program to projects" scope. Additionally, an Adolescent Project in place prior to 1981 continues to receive a share of Block Grant funds ($89,400) originally earmarked.

Special consolidated projects:
Title V MCH Block Grant funds continue to be used to carry out Sudden Infant Death Syndrome (SIDS) activities and the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP). SIDS activities include support for SIDS education and follow-up services. The Public Health Social Work Coordinator in MCH is responsible for coordination of SIDS activities. The CSHCN SSI-DCP uses funds to provide diapers, formula, durable medical equipment, supplies and services that would otherwise not be available to children with special health care needs.

State provides a reasonable portion of funds to deliver services:
The OSDH will continue to use MCH funds towards programs of priority for state and local needs. Assistance will continue to be provided to state and local agencies to: 1) identify specific MCH

areas of need; 2) plan strategies to address identified needs; and, 3) provide services to impact needs. Allocation of resources to local communities will continue to be based on factors such as: the identified need and scope of the particular health problem; community interest in developing service(s) to eliminate the problem, including the extent and ability to which local resources are made available; ability to recruit the specialized staff which are often needed to carry out the proposed service; the cost effectiveness of the service to be provided; coordination with existing resources to assure non-duplication of services; and, periodic evaluation to determine if resources have impacted the problem.

MCH continues to support a statewide Title V 1-800 toll-free information and referral system. MCH funds, in addition to federal funds from the Centers for Disease Prevention (CDC) and state general revenue funds, provide critical infrastructure services in newborn metabolic, hearing screening and birth defects surveillance.

The OKDHS administers the CSHCN Program through the Family Support Services Division (FSSD), Health Related and Medical Services Section. The FSSD also administers the SSI-DCP for SSI recipients to age 18. Other components of the CSHCN Program include two projects that support neonates and their families; support of the state Title V 1-800 toll-free information and referral system; sickle cell services; respite care services for medically fragile children; medical, psychological, and psychiatric services to the CSHCN population in the custody of the OKDHS; funding for travel, training, and child care for parents of children with special health care needs; a project that is establishing an integrated community-based system of services for children with special health care needs in several communities in the state; funding for a statewide mentorship program for families of children with special needs; and, funding of two parent advocates on a team that provides multi-disciplinary services to children in the autism clinic. Coordination continues between the FSSD and the Oklahoma Health Care Authority (OHCA) to assure services are not duplicated and policies and procedures are in compliance with federal and state mandates. The FSSD continues to utilize Title V funding to assure the development of community-based systems of services for children with special health care needs and their families.

Anticipated federal MCH dollars, state matching funds:
Based on a federal fiscal year (FFY) 2008 preliminary Title V Block Grant allocation of $7,399,286, a minimum of 30% ($2,219,786) must be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs. It is understood that the combined components must also meet the required match of three state dollars for each four federal dollars. These requirements will be met with estimated budgets reflecting the following as estimated validated program costs:

Budget	Title V	Cost Sharing	Total
Prevention and Primary Care for Children	$3,205,739 (43.32%)	$6,002,662	$9,208,401
Children with Special Health Care Needs	$2,219,786 (30.0%)	$1,665,033	$3,884,819
Maternal & Infant Care	$1,233,833 (16.68%)	$4,532,381	$5,766,214
Administration	$739,928 (10.0%)	$735,152	$1,475,080
Total	$7,399,286	$12,935,228	$20,334,514

/2009/ Based on a federal fiscal year (FFY) 2009 preliminary Title V Block Grant allocation of $7,401,402, a minimum of 30% ($2,220,421) must be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs. It is understood that the combined components must also meet the required match of three state dollars for each four federal dollars. These requirements will be met with estimated budgets reflecting the following as estimated validated program costs:

Budget	Title V	Cost Sharing	Total
Prevention and Primary Care for Children	$3,261,190 (44.06%)	$2,073,080	$5,334,270
Children with Special Health Care Needs	$2,220,421 (30.0%)	$1,675,052	$3,895,473
Maternal & Infant Care	$1,179,651 (15.94%)	$1,903,294	$3,082,945
Administration	$740,140 (10.0%)	$88,111	$828,251
Total	$7,401,402	$5,739,537	$13,140,939

//2009//

/2010/ For FFY 2010, based on a preliminary Title V MCH Block Grant allocation of $7,253,654, a minimum of 30% ($2,176,096) will be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs.

Budget	***Title V***	***Cost Sharing***	***Total***
Prevention and Primary Care for Children	***$3,094,175 (42.66%)***	***$1,913,181***	***$ 5,007,356***
Children with Special Health Care Needs	***$2,176,096 (30.0%)***	***$1,641,617***	***$3,817,713***
Maternal & Infant Care	***$1,258,018 (17.34%)***	***$1,989,191***	***$3,247,209***
Administration	***$725,365 (10.0%)***	***$62,270***	***$787,635***
Total	***$7,253,654***	***$5,606,259***	***$12,859,913***

//2010//

Other federal programs or state funds within MCH to meet needs and objectives:
The State Systems Development Initiative (SSDI), a grant funded by the Maternal and Child

Health Bureau (MCHB), continues activities to link Women, Infants and Children Supplemental Nutrition Program (WIC) data with birth certificates and Medicaid eligibility and claims data. This is a continuation of Oklahoma's goal to link relevant program services to existing MCH databases including the Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) surveillance systems. These linkages enable the state to generalize the results to Oklahoma's population of pregnant women (or new mothers) and young children.

The Early Childhood Comprehensive Systems Initiative (ECCS), a grant funded by the MCHB, provides funds for assisting in infrastructure building to facilitate implementation of the comprehensive state system plan for early childhood to include integration of child care activities. Implementation is being accomplished as a collaborative effort by multiple state agencies as well as community agencies.

The PRAMS, funded by the Centers for Disease Control and Prevention (CDC) with additional funds provided by MCH, continues to provide population-based data on maternal and infant health issues. This information is used to educate health care providers on maternal and infant health issues, recommend health care interventions, monitor health outcomes and provide support for state policy changes.

State line item funding continues for use in conjunction with Mott Foundation dollars to provide technical assistance in support of a sustainable structure (Oklahoma Afterschool Network) for high quality after school programs for Oklahoma children and youth. This structure has a priority of ensuring programs are available and accessible for low-income and hard-to-reach populations.

State line item funding continues for the Perinatal Continuing Education Program (PCEP) located on the University of Oklahoma Health Sciences Center campus. PCEP provides continuing education for medical and nursing staff providing perinatal services across the state.
/2010/ Negotiations with the OHCA have resulted in an addition to our interagency contract that will allow for Medicaid administrative match funds to be accessed to support expansion of this contract to focus on quality of care improvement activities as one of our partnership efforts to impact infant mortality and morbidity. //2010//

State line item funding continues to support two adolescent parenting projects, one in Oklahoma City and one in Tulsa. These projects provide maternity services to pregnant adolescent females as well as educational services to facilitate completion of high school and prevention of subsequent pregnancy.
/2010/ State line item funding for these projects was eliminated by the Legislature from the OSDH final appropriations bill this year. MCH is working with the projects providing information on potential federal, private and foundation funding opportunities to assist with their loss of state funds. //2010//

State line item funds were provided to the OSDH this year to implement Postponing Sexual Involvement (PSI) projects in targeted areas of the state to impact adolescent pregnancy. These funds will be distributed through an invitation-to-bid process.
/2009/ Four projects were awarded through a statewide Request For Proposals (three in Oklahoma County and one in Pittsburg County). //2009//
/2010/ A fifth project was awarded in Tulsa County. MCH requested ongoing funding through the OSDH legislative budget request for state fiscal year (SFY) 2010 as these state line item funds were one time with the funds to be exhausted during SFY 2010 unless additional funds are provided. With the current state budget deficit, the additional funds requested were not provided. As a result, MCH prioritized continued funding for two of the five projects for SFY 2010. Prioritization was based on contractor performance. Funds being used are lapse funds from the original revolving funds provided by the Legislature in SFY 2008. //2010//

State funds will continue to fund adolescent pregnancy prevention projects in targeted areas of

the state to include evaluation of the projects. Eight projects (four in county health departments and four in private non-profit agencies) will continue to provide health education services to youth in grades 6-8 and their parents/guardians. Evaluation of the projects will continue through the University of Oklahoma, College of Public Health.
/2009/ One private non-profit requested to end its contract this state fiscal year due to inability to provide match funds (one local dollar for every five state dollars). The remaining seven projects enter the fourth year of a five-year contract beginning July 1, 2008. //2009//
/2010/ Two county health department projects were put on hold this year when the project coordinators resigned. With budget deficits being experienced, OSDH leadership made the decision to utilize these state general revenue funds towards existing deficits within the OSDH budgets. For SFY 2010, an administrative decision has been made by the Deputy Commissioner of Family Health Services to maintain funding of the five current projects (two in county health departments and three in private non-profit agencies). The remaining state general revenue funds that have historically been used for these projects will be removed from MCH budgets and used to offset the budget reduction faced by the OSDH. //2010//

State funding continues for the OUHSC, College of Pharmacy, Poison Control Center. Funds are used to support staffing of a toll free information line and for educational activities to prevent poisonings.

State tobacco funds continue to be provided to the OSDH to fund school health nurses in priority areas of the state. The OSDH contracts with the OSDE for these services. The funds will be administered through MCH. MCH will work with the OSDE to provide support to the schools and school health nurses as they implement the eight interactive components of the CDC Coordinated School Health Model (health education; physical education; health services; nutrition services; counseling; psychological and social services; healthy school environment; health promotion for staff; and, family/community involvement).

State perinatal monies continue to be legislatively appropriated to the OSDH and are utilized by MCH to provide services for pregnant women and infants. These funds are used to support services such as the Healthy Mothers Healthy Babies Coalition, fetal and infant mortality review (FIMR) projects and maternity and infant clinical services.
/2010/ State perinatal funds and state general revenue funds are being realigned between MCH and Community Health Services, the area within OSDH responsible for oversight of county health departments. This realignment will provide MCH additional flexibility in providing population-based and infrastructure services towards efforts to reduce infant mortality (e.g., infant safe sleep education and training; breastfeeding support; preconception, interconception and postpartum education). State perinatal funds will be used by Community Health Services to support direct health care services for maternal and child health.

Another addition to the OHCA contract this year allows maximizing of state funds that support the FIMR projects with Medicaid administrative match funds. This will assist in expansion of the FIMR projects to the metropolitan statistical areas of Oklahoma City and Tulsa. //2010//

State funds, Medicaid funds and Title X federal funds continue to provide family planning services through county health departments and contract clinic sites. These funds are also used to provide a variety of educational programs targeted at decreasing unintended pregnancies, postponing sexual activity in teens, prevention of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), and increasing knowledge of human sexuality. April 1, 2007 began the third full year of the Oklahoma Medicaid Family Planning Waiver (Sooner Plan).
/2009/ The fourth year of the approved five year Medicaid Family Planning Waiver (Sooner Plan) began April 1, 2008. //2009//
/2010/ New Title X federal funds are being received for the next three years to support

special projects in Oklahoma and Tulsa counties targeting the African American population in efforts to impact access to services, use of services and significant disparities in infant mortality rates. Funds are being used to accomplish family planning outreach and education and provision of clinical services.

Oklahoma will be submitting a renewal application for its Medicaid Family Planning Waiver this fall. The original five-year project ends March 31, 2010. //2010//

The Oklahoma Health Care Authority will provide federal administrative funds through a contractual agreement to support data matching and analysis of Medicaid data with OSDH data. This information will be used for joint planning and evaluation of policy and services impacting the MCH population.
/2009/ In April, a shared staff position was filled. This position is housed and supervised within MCH. Expectations are that the individual will work with staff from both agencies in linking and analyzing Medicaid and OSDH data for sharing with policy and program staff to improve health systems and services. //2009//

The Oklahoma State Department of Education (OSDE) continues to provide federal funds received from the CDC to the OSDH through a contractual agreement. MCH uses these funds to support ongoing administration of the Youth Risk Behavior Survey. This survey provides Oklahoma with information on risk-taking behaviors of youth.

Budget Documentation:
Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants and contract acquisition staff meet routinely with program areas to assure program financial awareness. The MCH Chief is responsible for budget oversight and the Chief along with each individual Division Director is responsible for compliance with program standards and federal and state requirements.

The OSDH receives an annual independent audit of program and financial activities. The state's Office of the State Auditor and Inspector conducts this annual statewide single audit. The OSDH maintains an internal audit staff that reviews county health departments and subcontractors for compliance with contract fiscal matters relating to OSDH support. This staff reports directly to the Commissioner of Health. Additionally, MCH performs onsite program reviews with county health departments and contractors to assure programmatic compliance for both Title V and Title X.

The comptroller for the Family Support Services Division prepares and oversees the budget for the CSHCN Program. The CSHCN Director is responsible for compliance with federal and state requirements. CSHCN program staff monitor the budget and meet regularly to insure financial awareness within each budgeted area. CSHCN performs yearly onsite reviews with each contracted entity to insure program compliance. Each contractor also undergoes an independent audit. The state's Office of the State Auditor and Inspector conducts an annual audit of the CSHCN Program to assure compliance and accountability.
/2009/ The Title V Grant application documents a proposed budget on Forms 2, 3, 4 and 5 inclusive of Title V federal funds, state dollar match and anticipated income to be received from Medicaid. This budget is the base for services at the beginning of the grant period. As the year passes, the OSDH makes available more state and local funded resources (e.g. staff, supplies, travel) for provision of MCH services as an Agency priority. This results in increased funding reported as expended on Forms 3, 4 and 5. It is understood each year that these additional state and local funded resources are fluid and may be redirected at anytime by the Commissioner of Health based on a redirection of priorities, or in the event of a state health event or emergency/disaster needing to be addressed. //2009//
/2010/ There are no changes in the budget documentation process. //2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.